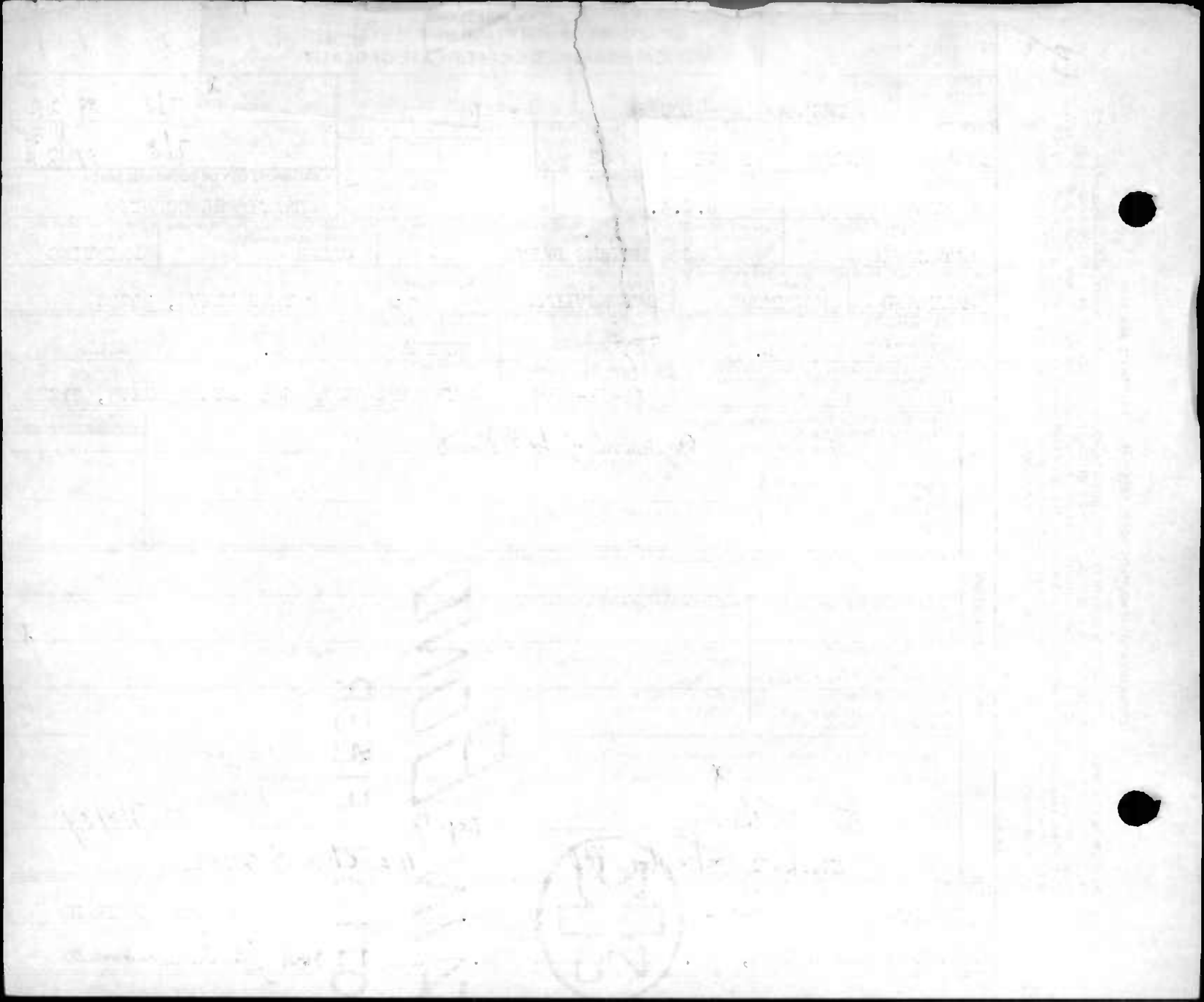


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |                                 |   |  |   |  |   |   | REG. NO. 17971  |  |
|--|--|-------------------------|---------------------------------|---|--|---|--|---|---|---|--|
| 1- STATE REGISTRAR   |  |                         |                                 |   |  |   |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THELMA LOUISE ABEL</b>  |  |                         |                                 |   |  |   |  |   |   | 2a. DATE KNOWN OF DEATH<br>MONTH <b>7/8</b> DAY <b>19</b> YEAR <b>1984</b> HOUR <b>28</b> M <b>M</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b> |                                 | 5. DATE OF BIRTH<br>MONTH <b>05</b> DAY <b>21</b> YEAR <b>16</b>  |  | 6. AGE (IN YEARS)<br>(1ST BIRTHDAY) <b>68</b> YRS.                                |  | 7. IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>   |   | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>7/8</b> DAY <b>19</b> YEAR <b>1984</b> HOUR <b>28</b> M <b>M</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |                         |                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  |                         |                                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>608 MEYERS DRIVE</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PRINTING</b>  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                         |                                 |   |  |   |  |   |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |                         | 13b. COUNTY<br><b>BALTIMORE</b> |   |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST <b>WILLIAM</b> MIDDLE <b>L.</b> LAST <b>ABEL</b>  |  |                         |                                 |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>BERTHA</b> MIDDLE <b>E.</b> LAST <b>WALL</b> |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |  |                         |                                 | 16b. SOCIAL SECURITY NO.<br><b>214-01-8601</b>  |  |   |  | 17. INFORMANT ADDRESS<br><b>CATHERINE ABEL 608 MEYERS DRIVE, 21228</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>conclusion of Left Heart</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |                         |                                 |   |  |   |  |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |                                 |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |                         |                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                         |                                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                         |                                 |   |  |   |  |   |   |   |  |
| ACTUAL SIGNATURE <u>Stanley Z. Rosenberg</u>   |  |                         |                                 | TITLE (SPECIFY) M.D. <u>Deputy</u>  |  |   |  | MEDICAL EXAMINER DATE SIGNED <u>7/2/84</u>  |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Stanley Z. Rosenberg MD</u>   |  |                         |                                 | ADDRESS <u>11 E. Chesebrough 21202</u>  |  |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         |                                 | 23b. DATE<br><b>07-11-84</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PARK</b>  |   |   |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>EIKRIDGE</b>   |  |                         |                                 | COUNTY<br><b>HOWARD</b>   |  |   |  | STATE<br><b>MARYLAND</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |                         |                                 | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 11 1984</b>   |   |   |  |
|  |  |                         |                                 |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Davidson</u>  |   |   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 1 - FOR  
 STATE  
 REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |                              |  |  |
|--|--|---|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HELEN L. ALBROMITIS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-24-1984</b> |   | 2b. HOUR<br><b>7:06 A.M.</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-19-1921</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                |  |
| 7a. BIRTH PLACE<br>(COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Kenilworth</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore Co. Gen. Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assembler</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gen. Electric</b>  |  |
| 13a. STATE<br><b>Ed.</b>   |  | 13b. COUNTY<br><b>Beth Co.</b>  |   | 13c. CITY OR TOWN<br><b>Woodlawn</b>  |                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>7140 Adelphi Road Rd. Gt. A.</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard C. Lizer</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara David Leback</b>  |                              | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |
| 16b. SOCIAL SECURITY NO.<br><b>220-05-3579</b>   |  | 17. INFORMANT<br><b>Alphonse A. Albromitis</b>  |   | 17. ADDRESS<br><b>7140 Adelphi Road Rd. Gt. A.</b>  |                              | 17. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>lung carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |   |   |                              |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <b>7-24</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |   |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>Michael Schwartz</b>  |  | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                              | 22c. DATE SIGNED<br><b>7/24/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR MICHAEL Schwartz MD.</b>  |  | 22e. ADDRESS<br><b>606 HAMMONDS LANE BALTO 21225</b>  |   |   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>  |  | 23b. DATE<br><b>7-27-1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood Bur. Pl.</b>   |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Worsey Howard Co. Ind.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. F. Cronin &amp; Son Inc.</b>   |  | ADDRESS<br><b>901 N. Hollins St.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 27 1984</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 17973

1 - FOR  
STATE  
REGISTRAR

REG. NO.

2041

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**John W Allgood**

2a. DATE OF DEATH MONTH DAY YEAR  
**07 30 84**

2b. HOUR  
**2350** M

3. SEX  
**Male**

4. RACE  
**Cauc.**

5. DATE OF BIRTH MONTH DAY YEAR  
**10 29 11**

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS  
**72**

IF UNDER 1 YEAR  
IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**Pennsylvania**

7b. CITIZEN OF WHAT COUNTRY?  
**U.S.A**

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**Baltimore County** MD.

10. CITY OR TOWN OF DEATH  
**Towson**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**Stella Maris Hospice**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**Field Engineering**

12b. KIND OF BUSINESS OR INDUSTRY  
**Bendix**

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN  
**Florida** **Marco Island**

13b. INSIDE CITY LIMITS? YES ☐ NO ☒

13c. STREET ADDRESS  
**Apt. 912 Tradewinds Condominium 180 Seaview Court 33937**

14. FATHER'S NAME FIRST MIDDLE LAST  
**William Allgood**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Isabelle Hall**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
**Yes WW 2**

16b. SOCIAL SECURITY NO.  
**216-10-1797A**

17. INFORMANT ADDRESS  
**Mrs. Eileen P. Lane 7417 Forrest Ave. 21234**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Brain metastases**  
DUE TO, OR AS A CONSEQUENCE OF (b) **lung cancer / small cell**  
DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **7/16**, 19 **84**, to **7/30**, 19 **84**, that (I) (we) last saw the deceased alive on **7/30**, 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE  
**R. Faulkner MD**

22c. DATE SIGNED  
**7/30/84**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**Burial**

23b. DATE  
**8-2-1984**

23c. NAME OF CEMETERY OR CREMATORY  
**Woodlawn**

23d. LOCATION CITY OR TOWN COUNTY  
**Baltimore Maryland**

24. FUNERAL DIRECTOR NAME ADDRESS  
**Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road**

25a. DATE REC'D. BY REGISTRAR  
**AUG 2 1984**

25b. REGISTRAR'S SIGNATURE  
*[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lillian V. Allison</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-13-1984</b>   |  | 2b. HOUR<br><b>10:25 PM</b>  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-4-1905</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>TOWSON</b>  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ARNOLD VOGEL</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SHAW</b>                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>212-50-3863</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>DR. ROBERT ALLISON - 8815 WOLVERTON RD. - TOWSON</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFICIENCY</b>   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>YEARS</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>   |   |   |   |  | "  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CORONARY INSUFFICIENCY</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2-9 1984</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (this hospital) attended the deceased from <b>2-9</b> 19 <b>84</b> , to <b>7/13</b> 19 <b>84</b> , that (s/he) lost saw the deceased alive on <b>7-13</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (If two) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Alberto J. Diaz</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>7-13-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALBERTO J. DIAZ MD</b>  |   | 22e. ADDRESS<br><b>7600 OSLER DR., TOWSON, MD. 21204</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |   | 23b. DATE<br><b>7/14/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |   | ADDRESS<br><b>Balto., Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 17 1984</b>                                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 7 9 7 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

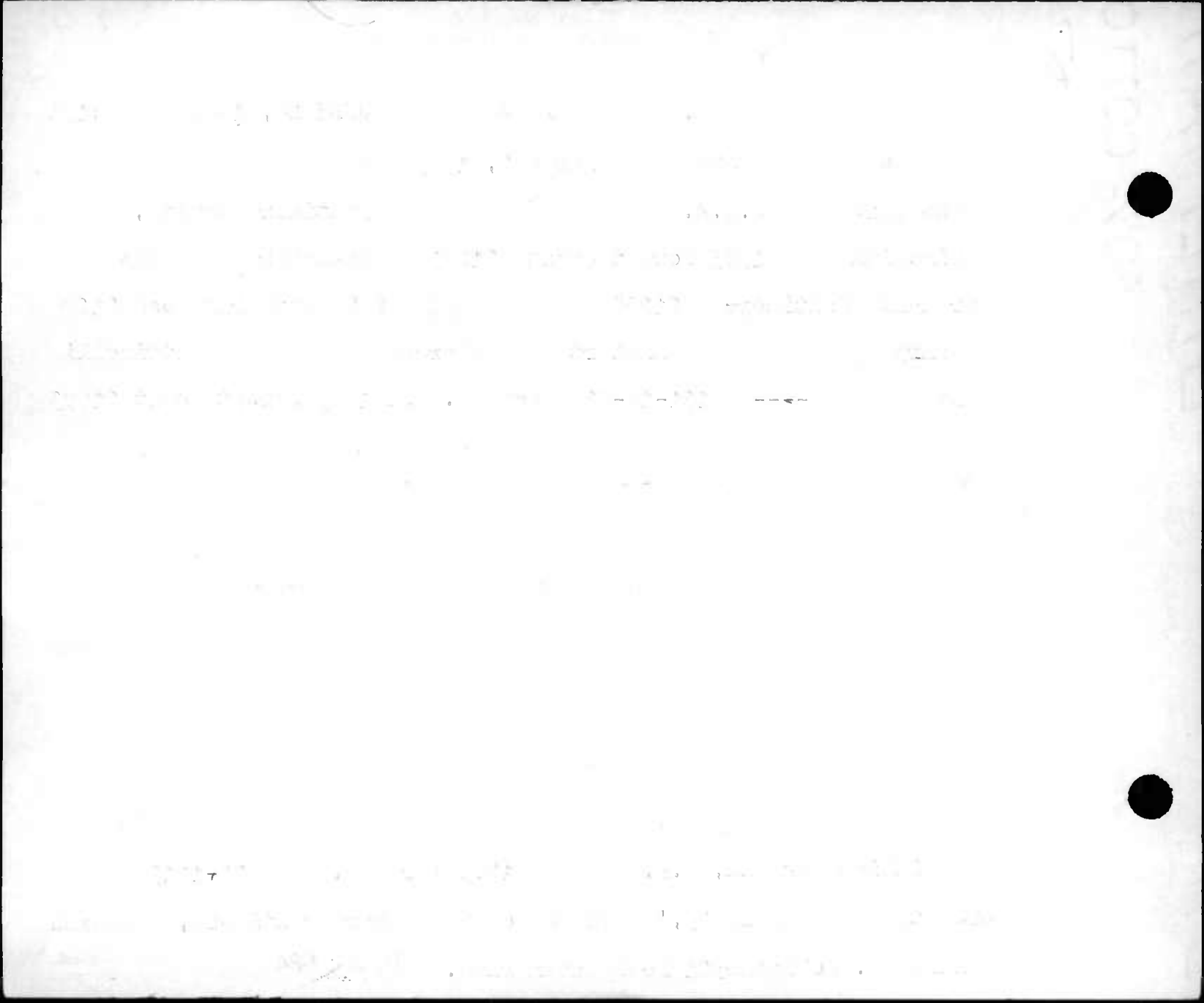
|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNA R. ALTHAUS</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 24, 1984</b>                          |   | 2b. HOUR<br><b>8:15AM</b>                                       |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 2, 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>New York</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Timonium</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1905 Forest Court 21093</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                |
| 13a. STATE<br><b>Maryland</b>  |   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>21204</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Englert</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Theresa Attinelli</b>            |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>131-14-3200</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Joan A. Rose 1905 Forest Court 21093</b>               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Diffuse bronchogenic Carcinoma</b>  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 yr</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |   |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>PULMONARY FIBROSIS; PNEUMONITIS</b>  |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-10</b> , 19 <b>84</b> , to <b>6-5</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>6-5</b> , 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |   |
| 27b. SIGNATURE<br><b>W E Randall Jr</b>  |   |   |  | 27c. DATE SIGNED<br><b>7/24/84</b>  |   |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William Randall, M.D.</b>  |   |   |  | 27e. ADDRESS<br><b>1205 York Rd. 823-1313</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |   | 23b. DATE<br><b>July 25, '84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery Baltimore, Maryland</b> |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>  |   | ADDRESS<br><b>8521 Loch Raven Blvd.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 24 1984</b>                                   |   |
|  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>William E. Johnson</b>                               |   |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP









STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1 - STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GLADYS ANDERSON</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7/17/84</b><br>2b. HOUR<br><b>3:55PM</b>   |  |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 20 05</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b><br>YRS. MONTHS DAYS HOURS MIN.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  |
| 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Berry Anderson</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gladys</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-48-3321</b>   |  |
| 17 INFORMANT<br><b>Mr. William G. Anderson, 1205 Wine Spring Ln.</b>  |  | ADDRESS<br><b>Towson, Md.</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>VENTRICULAR TACHYCARDIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MYOCARDIAL INFARCTION</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 MINN</b><br><b>30 MIN</b><br><b>1-2 DAYS</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/17</b> <b>84</b> to <b>7/17</b> <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/17</b> <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |
| 22b. SIGNATURE<br><b>Mary Ann D. Moore MD</b>   |  | 22c. DATE SIGNED<br><b>7-17-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR M MOORE</b>  |  | 22e. ADDRESS<br><b>GBMC</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>7/17/84</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 18 1984</b>   |  |
| ADDRESS<br><b>Balto., Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>   |  |

BP

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#14, 16b, Film G594 8/24/84  
 FOR  
 1 - STATE  
 REGISTRAR  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8-4 17978

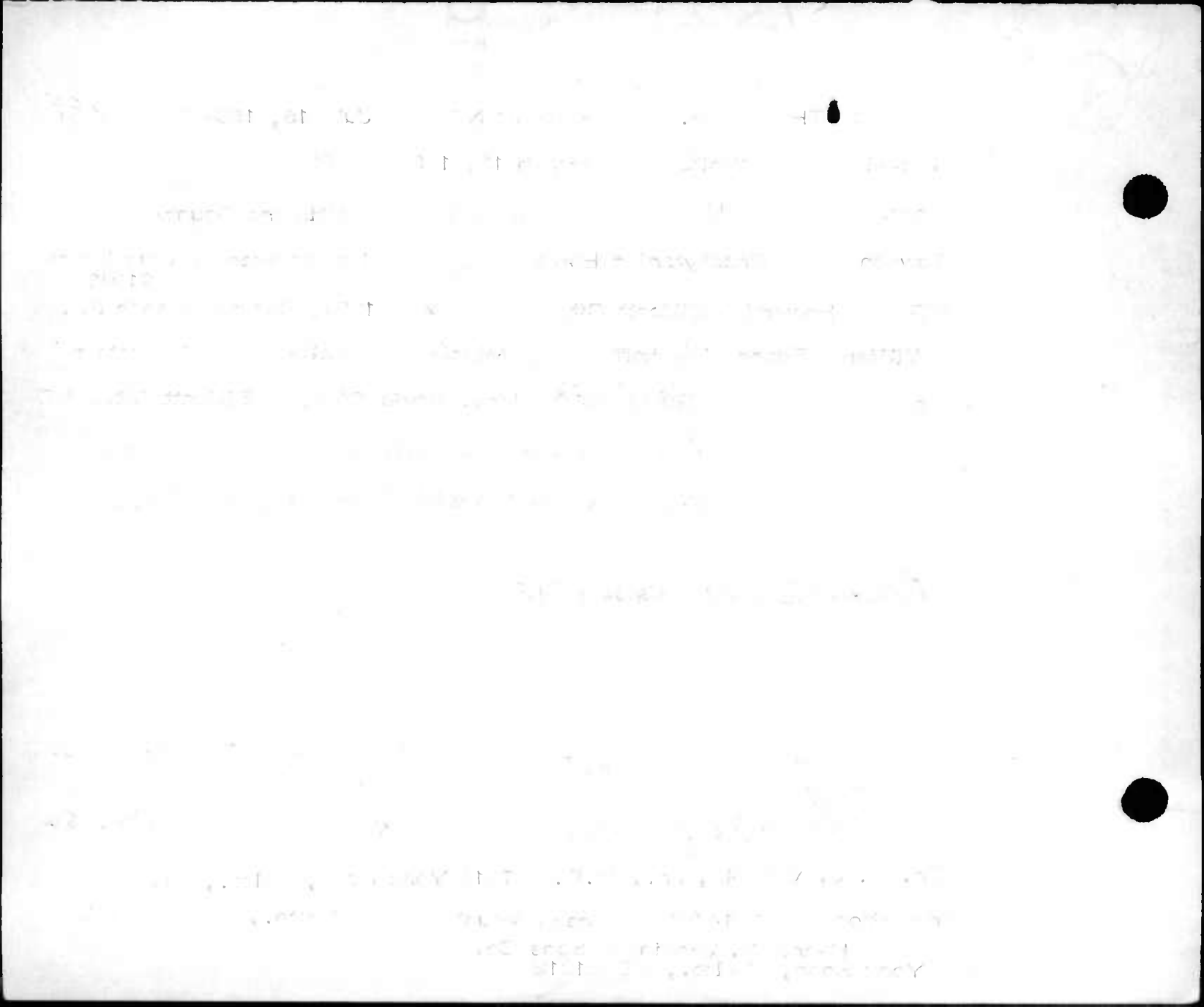
|   |  |  |   |   |  |  |   |  |  |
|---|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ROTH B. ARMSTRONG  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 15, 1984                    |   |  | 2b. HOUR<br>9:05 P.M.  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 13, 1894  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS  |   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Iowa  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Presbyterian Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |   |  |  |
| 13a. STATE<br>MD  |  |  | 13b. COUNTY<br>Howard   |   | 13c. CITY OR TOWN<br>Ellicott City   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Edgar Bischoff  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie Belle Armstrong |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. (IF YES, GIVE WAR OR DATES)  |   | 17. SOCIAL SECURITY NO.<br>213-87-33200  |  |   | 18. INFORMANT<br>ADDRESS<br>Mrs. David Fink, Ellicott City, MD   |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>  |  |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>MIN  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |   |  |  | 4 yrs   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Rheumatic CVD &amp; Chronic CHF.</u>  |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-13-79</u> to <u>July 15, 1984</u> , that (I) (lost) saw the deceased alive on <u>July 15, 1984</u> , and that (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death. |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Dr. S. J. Venable, Jr.</u>   |  |  | DEGREE<br>M.D.  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>7-16-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. S. J. Venable, Jr., M.D.   |  |  | 22e. ADDRESS<br>7215 York Road, Balto., MD                              |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>7/16/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road, Balto., MD 21212   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 17 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |  |  |

BP

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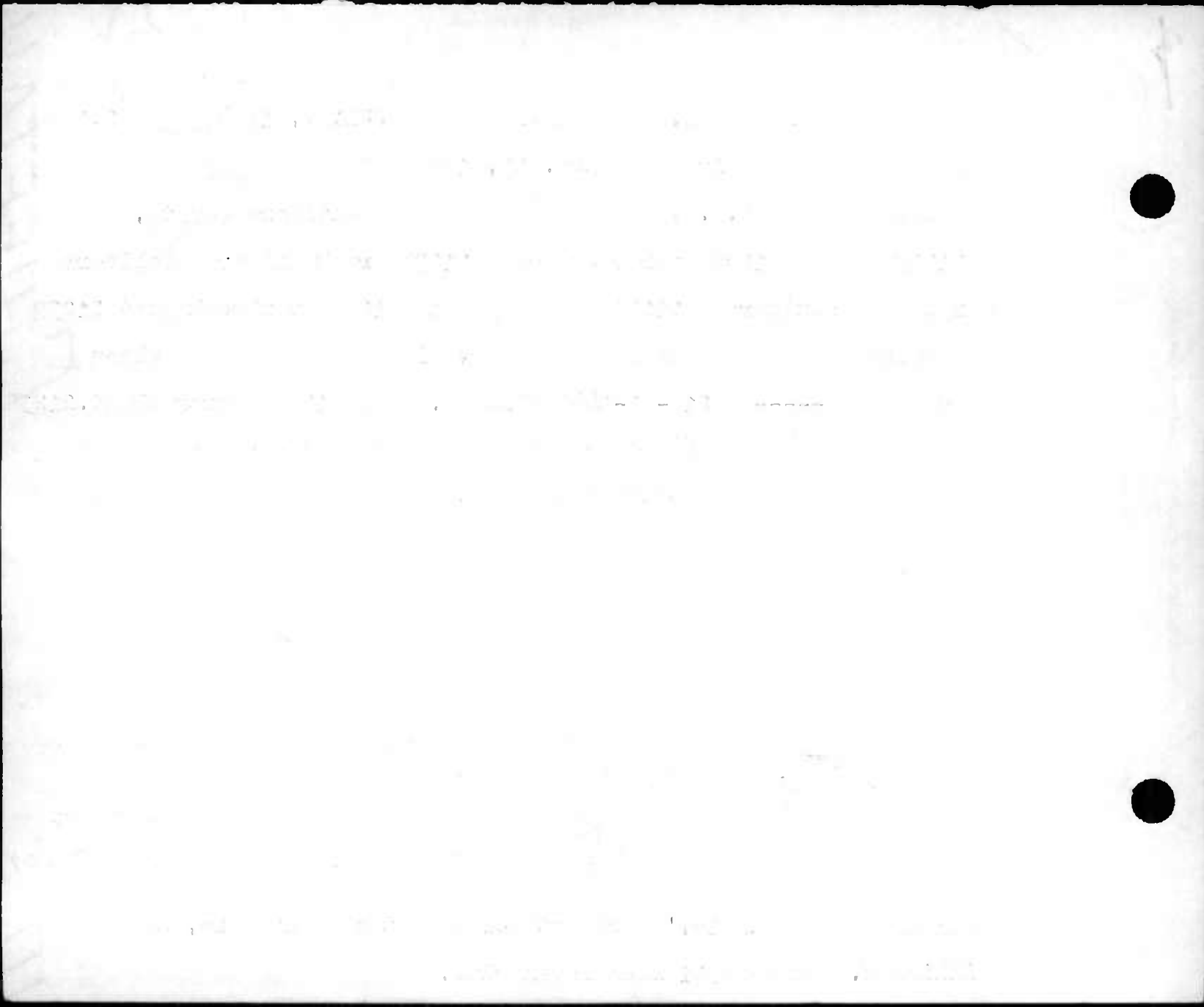


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
|--|--|--|--|--|--|---|--|--|--|-----------------|--|-------|--|------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH                            |  |                 |  | MONTH |  | DAY  |  | YEAR |  | 2b. HOUR |  |
| CHARLES A. ASPLEN  |  |  |  |  |  |   |  | JULY 7, 1984                                 |  |                 |  |       |  |      |  |      |  | 2:30AM   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS |  |       |  |      |  |      |  |          |  |
| Male   |  | White  |  | Nov. 23, 1906  |  | 77  |  | MONTHS                                       |  | DAYS            |  | HOURS |  | MIN. |  |      |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| Maryland   |  | U.S.A.   |  |  |  | Baltimore County, MD.   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 21239  |  | 1206 Overbrook Road 21239  |  | Truck Driver   |  | Delivery  |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE               |  |                 |  |       |  |      |  |      |  |          |  |
| Maryland   |  | Baltimore  |  | 21239  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1206 Overbrook Road 21239                    |  |                 |  |       |  |      |  |      |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| Howard   |  | Pauline  |  |  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| No   |  | 217-03-3446  |  | Hilda C. Asplen  |  | 1206 Overbrook Rd. 21239  |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                 |  |       |  |      |  |      |  |          |  |
|  |  | MYOCARDIAL INFARCTION  |  | HSCVD  |  |   |  | MINS   |  |                 |  |       |  |      |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                    |  |  |  |  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |                 |  |       |  |      |  |      |  |          |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
|  |  | P.M. 19  |  |  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET   |  | CITY OR TOWN  |  | COUNTY                                       |  | STATE           |  |       |  |      |  |      |  |          |  |
|  |  |  |  | 12-3   |  | 76  |  | 7-7  |  | 84              |  |       |  |      |  |      |  |          |  |
| 22a. I certify that (I) (the medical) attended the deceased from   |  | 19 84, to 7-7, 19 84, that (I) (we) lost   |  |  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| saw the deceased alive on  |  | above, (I) (we) (and) pronounced the body after death  |  |  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| RICHARD D. B. 1985   |  |  |  | 7-7-84   |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
|  |  | 7100 58th St DR 21204  |  |  |  |   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| Burial   |  | July 10, '84   |  | New Cathedral Cemetery   |  | Baltimore, MD   |  |  |  |                 |  |       |  |      |  |      |  |          |  |
| 24. FUNERAL DIRECTOR   |  | NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                   |  |                 |  |       |  |      |  |      |  |          |  |
| William E. Johnson   |  | 8521 Loch Raven Blvd.  |  |  |  | JUL 9 1984  |  |  |  |                 |  |       |  |      |  |      |  |          |  |

BP





**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 4 1 / 9 8 0

FOR  
 1 - STATE  
 REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROSA ASRAEL</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 05 84</b>                          |   |  | 2b. HOUR<br><b>10 35 AM</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 14, 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PHILIP GOLDMAN</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH RUDMAN</b>           |   |  | 16. STREET ADDRESS / ZIP CODE<br><b>1607 WOODLING WAY #21208</b>                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO OR UNKNOWN (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-28-3154</b>                                 |   | 17. INFORMANT<br><b>SAMUEL ASRAEL</b><br><b>1607 WOODLING WAY BALTO., MD 21208</b> |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac asystole</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hemorrhagic Irreversible Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Upper G.I. Bleeding due to Duodenal-venacaval fistula by metastasis.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Metastatic retroperitoneal mass secondary to Ca. uterus.</b>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>7-3-84</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>upper G.I. Bleeding</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)     |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |  |  |  |
| 22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>July 3rd</b> , 19 <b>84</b> , to <b>July 5th</b> , 19 <b>84</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>July 5th</b> , 19 <b>84</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, <del>(I/we)</del> <del>(did not)</del> view the body after death.                                  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Merchant Deepak MD</b>  |  |   |  |   | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7-5-84 10:35 AM</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Deepak Merchant</b>  |  |   |  |   | 22e. ADDRESS<br><b>3350 Wilkens Ave. MD-21229.</b>                                 |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>7/6/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 10 1984</b>                                |  |  |  |  |
|  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>                                |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF DEATH OCCURS AT HOME, PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF DEATH OCCURS IN A HOSPITAL, PAGE 6 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                   |   |  |                                      |  |  |          |
|--|--|-------------------|---|--|--------------------------------------|--|--|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                   | 2a. DATE KNOWN<br>OF ESTI.<br>DEATH MATED   |  |                                      | 2b. HOUR   |  |          |
| COLE H ATWOOD  |  |                   | July 19, 1984   |  |                                      | 12:52 PM   |  |          |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | IF UNDER 1 YR.   | IF UNDER 24 HRS.                     | 2c. DATE<br>PRONOUNCED<br>DEAD   |  | 2d. HOUR |
| MALE   | W  | 08/26/24          | 59 YRS.   |  |                                      | July 19, 1984  |  | 12:57 PM |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |          |
| New York   | U.S.A.   |                   |   |  | COUNTY                               |  |  |          |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) |                                      | 12b. KIND OF BUSINESS<br>OR INDUSTRY   |  |          |
| TOWSON   | ST JOSEPH HOSPITAL   |                   |   | Publisher  |                                      | Self Employed  |  |          |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                   |   |  |                                      |  |  |          |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS  |                                      |  |  |          |
| PENNA  | York   | Dover             |   | RD #4 P.O. Box 101 17315   |                                      |  |  |          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |                                      |  |  |          |
| Atwood   |  |                   |   |  |                                      |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |                   | 16b. SOCIAL SECURITY NO.  |  |                                      | 17. INFORMANT<br>ADDRESS   |  |          |
| Yes  |  |                   | W.W II  |  |                                      | Ilona G. Atwood RD #4 P.O. Box 101 17315   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cordial Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Esophageal Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cirrhosis of Liver</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |  |                   |   |  |                                      |  |  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITIONS GIVEN IN PART 1 (a):   |  |                   |   |  |                                      |  |  |          |
| 19a. DATE OF OPERATION   |  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                                      | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| 20a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                                      | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |          |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                   | 21b. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |                                      | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                   |   |  |                                      |  |  |          |
| ACTUAL SIGNATURE   |  |                   | TITLE (SPECIFY)   |  |                                      | DATE SIGNED  |  |          |
| Charles F. O'Donnell, M.D.   |  |                   | Deputy Medical Examiner   |  |                                      | 7/19/84  |  |          |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                   | ADDRESS   |  |                                      |  |  |          |
| Charles F. O'Donnell, M.D.   |  |                   | 7501 York Rd. 823-3161  |  |                                      |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |                   | 23b. DATE   |  |                                      | 23c. NAME OF CEMETERY OR CREMATORY   |  |          |
| Cremation  |  |                   | July 21, '84  |  |                                      | Green Mount Cemetery Bal   |  |          |
| 24. FUNERAL DIRECTOR<br>NAME   |  |                   | 25a. DATE REC'D. BY   |  |                                      | 25b. LOCATION<br>CITY OR TOWN  |  |          |
| William E. Johnson   |  |                   | 8521 Loch Raven Blvd.   |  |                                      | Julia Davidson-Randall   |  |          |

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10/1/1900  
July 19 1900

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MALE

COUNTY

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ST JOSEPH HOSPITAL

TOWSON

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1000

10/1/1900  
10/1/1900  
10/1/1900

*[Faint handwritten notes and signatures]*

10/1/1900  
10/1/1900  
10/1/1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 7 9 8 2

REG. NO.

|  |  |   |  |   |   |  |                                   |  |
|--|--|---|--|---|---|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>BERTHA BELLE AUODOUN   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 14, 1984 |   | 2b. HOUR<br>M   |  |                                   |  |
| 1. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 8, 1897   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.   |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Armcast Nursing Home |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |   |  |                                   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Smith  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Virginia Fox   |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-12-9150  |  | 17. INFORMANT<br>ADDRESS<br>Oliver Auodoun, Jr. 6705 PARKWAY RD. 21239  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Respiratory Failure Sudden</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Breast</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 ± yrs<br>8 yrs   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.   |  |   |  |   |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/2/81</u> to <u>14 July 81</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>14 July 81</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)                     |  |   |  |   |   |  |                                   |  |
| 22b. SIGNATURE<br><u>Charles F. O'Donnell</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED  |   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles F. O'Donnell, M.D.  |  |   |  | 22e. ADDRESS<br>7501 York Rd. Towson, Md. 21204   |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>July 17, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn, Balto. Co., Md.  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto., Md. 21212  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 18 1984  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Ryder</u>   |                                   |  |

BP



STATE OF CALIFORNIA

COUNTY OF SAN DIEGO

BEFORE ME, the undersigned authority, on this day personally appeared

*[Handwritten signature]*

*[Handwritten signature]*

Witness my hand and seal this day of

at the County of San Diego, State of California.

*[Faint handwritten text at the bottom of the page]*



## REG. NO.

230. BURIAL  
SPECIES

BP



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-334211)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]

RE: [Illegible]

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

NY 100-100000

RECEIVED  
JUL 1 1964  
FBI NEW YORK

100-100000  
JUL 1 1964  
FBI NEW YORK

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 7 9 8 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDWARD J. BACON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>17</b> YEAR <b>'84</b> 2b. HOUR <b>4:55A</b>         |  |  |
| 3 SEX<br><b>MALE</b>   | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>17</b> YEAR <b>02</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE COUNTY</b> MD                        |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farmer</b> |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Monkton</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Samuel</b> MIDDLE <b>R.</b> LAST <b>Bacon</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Belle</b> MIDDLE <b></b> LAST <b>Benson</b>                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>243-10-0371-A</b>   |   | 17 INFORMANT<br><b>S.R. Bacon</b> ADDRESS <b>845 Corbett Rd. 21111</b>               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b></b>   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/13</b> , 19 <b>84</b> , to <b>7/17</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>7/17</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                     |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Diane Pappas MD</i>   |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>7/17/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Diane Pappas MD</b>  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7-20-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. James Church</b>                        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Monkton Baltimore, Maryland</b>   |  | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home Inc. Towson, 21204</b>  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 20 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |  |  |

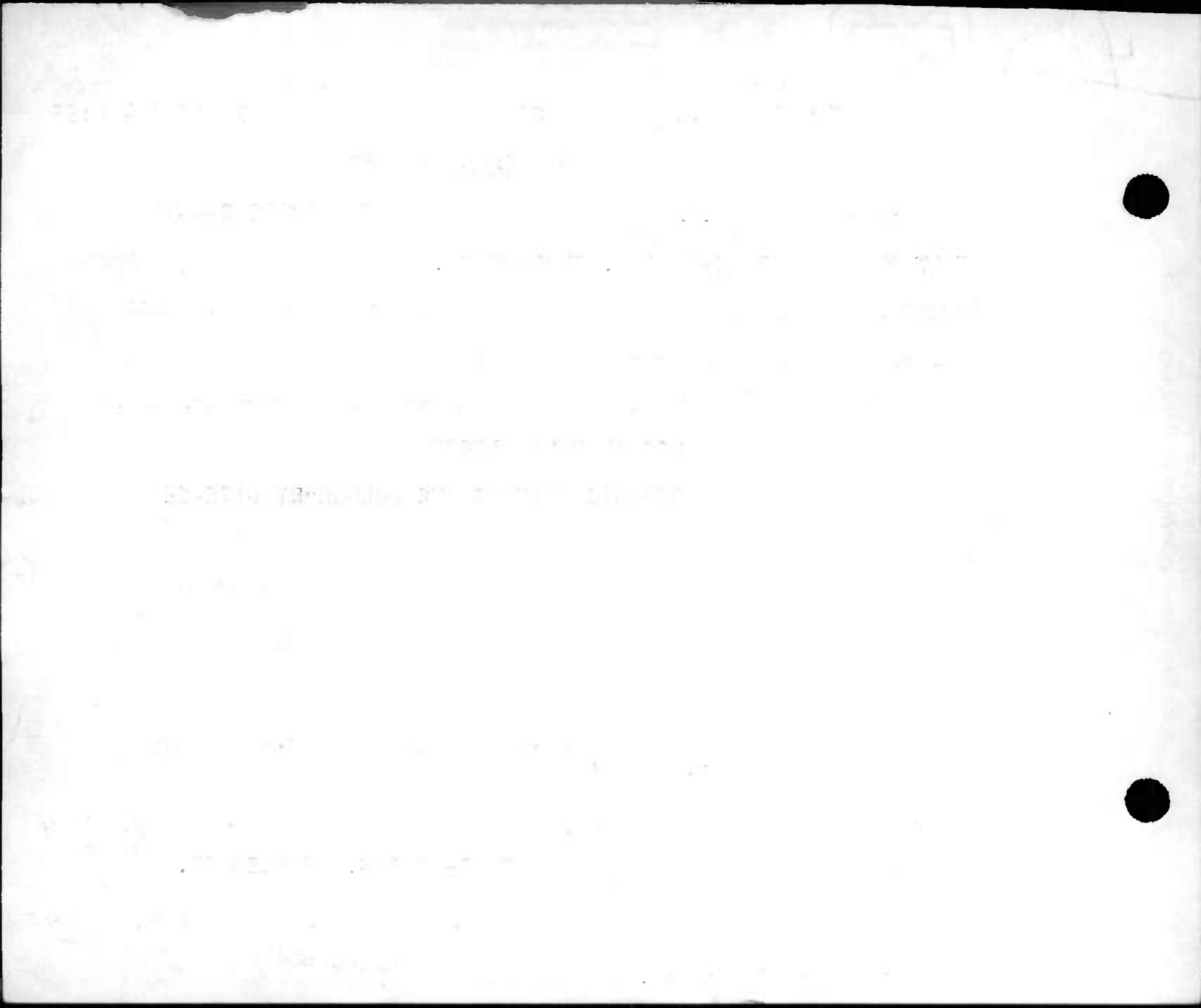
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Helen Leona Ball</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>7-27-84</i> |   | 2b. HOUR<br>MIN<br><i>1<sup>00</sup> A M</i> |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 26 14</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN<br><i>69</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>UNITED STATES</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE COUNTY MD</i>   |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>RIVER VIEW NURSING CENTER</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Secretary</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Union Printing</i>   |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>   |   | 13c. CITY OR TOWN<br><i>Dundalk</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William R. Ball</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Bessie Bankard</i>  |   | 16. ADDRESS<br><i>258 St. Helena Ave. Dundalk, MD 21222</i>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>410-03-2047</i>  |   | 17. INFORMANT<br><i>Louise Muse</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic carcinoma of breast</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 years</i> |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (18)  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 19 1983</i> to <i>July 27 1984</i> that (I) (we) lost<br>saw the deceased alive on <i>July 23 1984</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not see the body after death.   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>MORRIS RAINES, MD</i>  |  | DEGREE<br><i>MD</i>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>7.27.84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MORRIS RAINES, MD</i>   |  | 22e. ADDRESS<br><i>1105 OLD EASTERN AVE 21221</i>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>07/30/1984</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Mem. Park</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Elkridge Maryland</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Walter Brooks Bradley, Inc. Dundalk, MD 21222</i>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 30 1984</i>   |  |  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

BP



JUL 30 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 17986

FOR  
1 - STATE  
REGISTRAR

REG. NO.

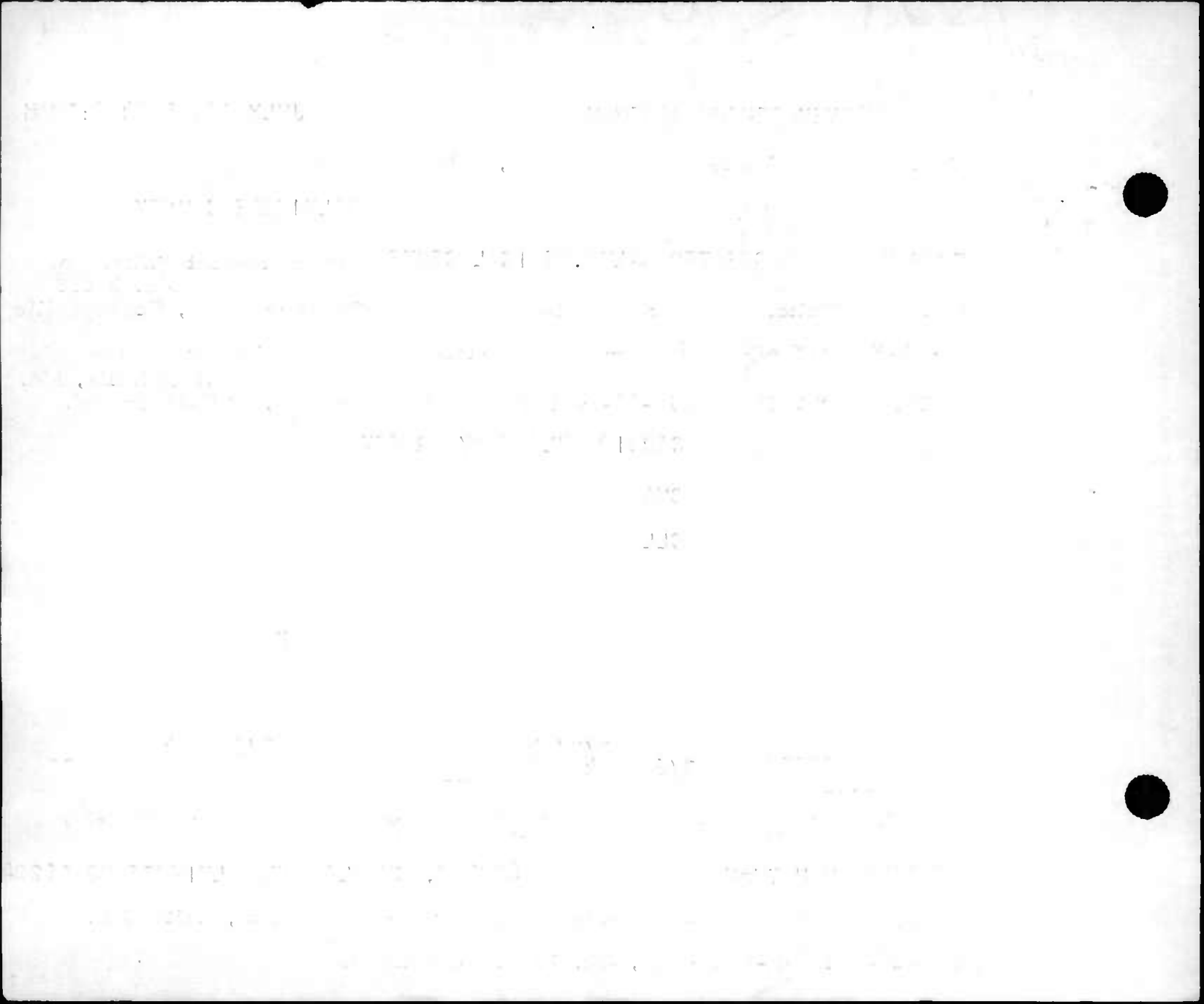
|  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARVEY BENSON BAREHAM</b>   |  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 06, 1984</b>   |  |  |  | 2b HOUR<br><b>8:30AM</b>  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sep. 8, 1916</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTO. MEDICAL CENTER</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Superintendent</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Balto. Co.</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Cockeysville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e STREET ADDRESS / ZIP CODE<br><b>Md. 21030</b><br><b>222 Warren Rd., Cockeysville</b>                                  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harvey Howard Bareham</b>  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Nailor</b>  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b SOCIAL SECURITY NO.<br><b>WW II</b>  |  | 17 INFORMANT<br><b>Mr. Neil J. Bareham, 12 Oakmere Rd.</b>   |  | ADDRESS<br><b>Owings Mills, Md.</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>  |  |  |  | 21117  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>CVA</b>  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CLL</b>   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |  |  |   |  |
| 22. I certify that (I) (the hospital) attended the deceased from <b>7/2/84</b> 19 <b>84</b> , to <b>7/6</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/6</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |
| 22b SIGNATURE<br><i>Howard Hauptman</i>  |  |  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>7/6/84</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HOWARD HAUPTMAN</b>   |  |  |  | 22e ADDRESS<br><b>6701 N. CHARLES ST. BALTIMORE, MD 21204</b>  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>7/9/84</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>  |  | 23d LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br><b>Timonium, Balto. Md.</b>   |  |   |  |
| 24 FUNERAL HOME<br><b>Lennon-Mitchell-Wiedefeld, Inc. 10 W. Padonia</b>  |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 9 1984</b>  |  | 25b REGISTRAR'S SIGNATURE<br><i>Robert R. Rindell</i>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1- FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8 4 1 7 9 8 7  |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | REG. NO.   |  |
| 1a. DECEASED NAME<br>FIRST MIDDLE LAST<br><i>Walter Earl Barnhart</i>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>7 6 84</i>   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>  |  | 2b. HOUR<br><i>7:05 A.M.</i>   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 24 90</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>94</i>   |  | 7. HOUR<br><i>7:05 A.M.</i>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i>                                    |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Valley View Nursing Home</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Superintendent</i>          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Towson</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Walter Howard Barnhart</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Laura Virginia Reaver</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>214-40-5229</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Edythe B. Hoopes 1008 Malvern Avenue</i>                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Dehydration</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Organic Brain SD</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Bed sores</i>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/1/83</i> to <i>7/6/84</i> , that (I) (we) last saw the deceased alive on <i>7/2/84</i> , and that in (my) (our) last opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Vuong Vu</i>  |  | DEGREE   |  | 22c. DATE SIGNED<br><i>7/6/84</i>  |  |
| 22d. PHYSICIAN'S NAME (LAST, FIRST)<br><i>VUONG VU NGUYEN</i>  |  | 22e. ADDRESS<br><i>6331 Belair Rd Balto 21206</i>  |  | 22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>July 9, 1984</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood</i>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i>   |  | 23e. DATE REC'D. BY REGISTRAR  |  | 23f. REGISTRAR'S SIGNATURE<br><i>W. W. Wiedefeld</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Mitchell-Wiedefeld Home</i>   |  | ADDRESS<br><i>6500 York Road</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 10 1984</i>  |  |

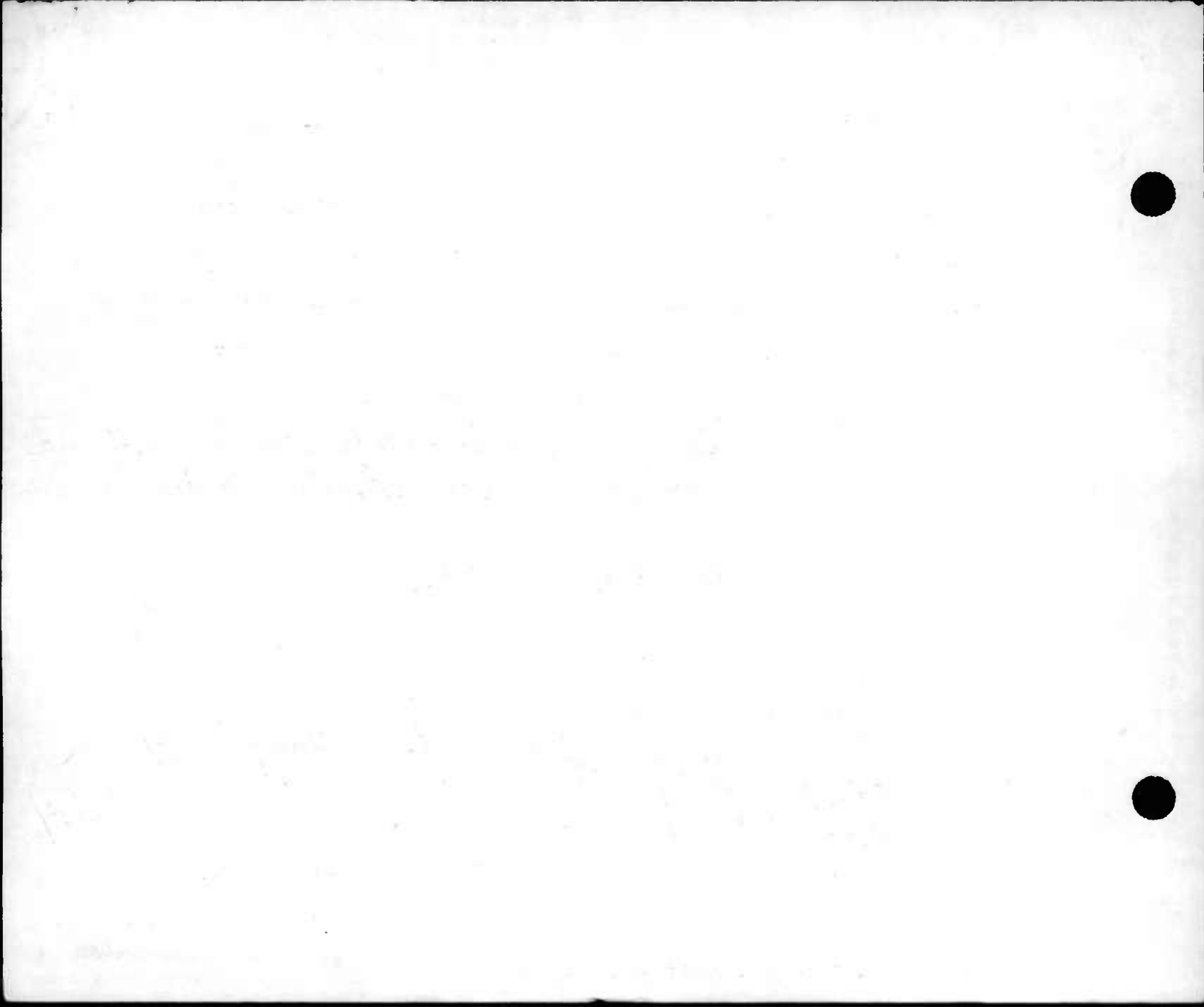


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |   | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2b. DATE OF DEATH  |   | 2b. HOUR   |  |
| MRS. Lillian L. Bassford  |   | July 31, 1984  |   | 11 45 AM   |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE  | 7. UNDER 1 YEAR  |  |
| female  | white   | July 20, 1912  | 72  | MONTHS DAYS HOURS MINS   |  |
| 8. BIRTHPLACE   | 7b. CITIZEN OF WHAT COUNTRY?                            | 8. MARRIED   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| Maryland  | USA   | NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore County MD   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Parkville   | 8821 Baker Avenue                                       | Housewife  |   |  |  |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |  |  |
| Md.   | Baltimore   | Parkville  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME   |   | 16. STREET ADDRESS / ZIP CODE                                  |  |
| Milton K. Holbrook  |   | Jeannette Bernhard   |   | 8821 Baker Avenue 21234  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |   | 17b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |
| no  |   | 215-34-9668  |   | Mr. Samuel F. Bassford Same                                    |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction &amp; Arrhythmia</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Arteriosclerotic Cardio-vasc. Dis.</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i> |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d):  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   |  |   |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |   | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED                                       |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | HOUR A.M. MONTH DAY YEAR   |   | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)          |  |
|   |   | P.M. 19  |   |  |  |
| 22a. INJURY OCCURRED  |   | 22b. PLACE OF INJURY   |   | 22c. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |   | CITY OR TOWN COUNTY STATE                                      |  |
| 22d. I certify that (i) [this hospital] attended the deceased from 7/27/84 to 7/31/84, that (ii) [I] last saw the deceased alive on 7/27/84, and that in my [ ] opinion death occurred on the date and hour and from the causes stated above, (iii) [ ] and [ ] will follow the body after death.   |   | 22e. SIGNATURE   |   | 22f. DATE SIGNED   |  |
|   |   | Frank T. Kasik   |   | 7/31/84  |  |
| 22g. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22h. ADDRESS   |   |  |  |
| Frank T. Kasik  |   | 9005 Harford Rd. Baltimore Md 21234  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION   |  |  |
| Burial  | Aug. 2, 1984  | Wards Chapel   | Randallstown Balto. Md.   |  |  |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Leonard J. Ruck Inc. Baltimore, Maryland  |   | AUG 1 1984   |   | [Signature]  |  |

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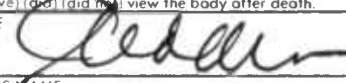
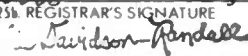


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elmer E. Beck Jr.</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 26, 1984</b>                                     |   | 2b. HOUR<br><b>M</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 1, 1911</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1710 Melbourne Road 21222</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bethlehem Steel</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Dundalk</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1710 Melbourne Road 21222</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmer E. Beck</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Elizabeth Beall</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>217-09-5779</b>  |   | 17. INFORMANT <b>Mr. Walter Beck</b><br><b>4013 Buckingham Road 21207</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.                                     |   |   |   |   |  |
| 22b. SIGNATURE<br>   |   | DEGREE<br><b>MD.</b>  |   | 22c. DATE SIGNED<br><b>7/27/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CLIFF E. PARRA, M.D.</b>  |   | 22e. ADDRESS<br><b>7122 HARFORD ROAD<br/>BALTIMORE, MD. 21224</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>7/30/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pleasant Hill Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills Baltimore, MD.</b>                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>   |   | ADDRESS<br><b>8728 Liberty Road Randallstown, MD. 21133</b>   |   | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 30 1984</b>  |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br> |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |  |  |   |  | REG. NO. 4 17990  |  |
|---|--|-------------------------|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |                         |  |   |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAULINE T BEES</b>   |  |                         |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>July 1 1984</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 20 1899</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>85 YRS.</b>      |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 2b. DATE<br>Pronounced DEAD <b>July 1 1984</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         |  |   |  |  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |                         |  |   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>3326 Lawnview Ave 21213</b>   |  |                         |  |   |  |  |  |   |  | 13f. CITY OR TOWN<br><b>PICKERSGILL HUSBAND HOME</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph P. Obst</b>   |  |                         |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Mae</b>                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |                         |  |   |  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>159-07-6447</b>  |  |
| 17. INFORMANT<br><b>Pickersgill Home, 615 Chestnut Ave. 21204</b>   |  |                         |  |   |  |  |  |   |  | ADDRESS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Generalized ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5+ yrs</b>   |  |                         |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |                         |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                         |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b>   |  |                         |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  |  |  | MEDICAL EXAMINER<br>DATE SIGNED <b>7/1/84</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Charles F. O'Donnell M.D.</b>  |  |                         |  | ADDRESS<br><b>7501 York Road, Towson, Md. 21204</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>7-5-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  |                         |  | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>na Davidson</b>  |  |

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PAID  
JAN 20 1952

Baltimore County

U.S.A.

Maryland

Towson

ST JOSEPH HOSPITAL

Boothsperger

3336 Lanthier Ave. 21213

XXXXXXXXXXXXXXXXXXXX

Baltimore

Maryland

Female

Child

P.

Joseph

Male

Pickerskill Home, 615 Chestnut Ave. 21204

177-27-2447

No

Maryland

Baltimore

London Park

7-1-84

Funeral

1950 York St.

John Brown Funeral Home, Inc. Towson, Md. 21204



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 84 179991   |   |  |  |
|--|--|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>August BENDER</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 14, 1984</b>  |  |  |   | 2b. HOUR<br><b>11:00pm</b>                   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>August 13, 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS  |   | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Glen L Martin</b> |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>✓</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3101 Glenmore Ave 21214</b>   |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>? ? Bender</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown</b>  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-0148</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs Emma R Bender Same As 13e</b>                                   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>   |  |  |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bladder Cancer</b>  |  |  |  |   |  |   |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 19, 1984</b> to <b>July 14, 1984</b> , that (I) (we) last saw the deceased alive on <b>July 14, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>J. M. Niehoff</b>   |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7/14/84</b>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. M. NIEHOFF, MD</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/18/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |                              |  |  |
|---|--|--|--|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNA Dorothy BERGNER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 30 1984</b> |   | 2b. HOUR<br><b>1:50 A.M.</b> |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 22 1898</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b><br>YRS MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. cytologist</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2224 Kentucky Ave 21213</b>  |                              |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Bergner</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Birkenstock</b>  |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215 28 3479</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>C. Richard Lehnert Sparks, Md.</b>   |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.          |  |  |  |   |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (If)  |  |  |  |   |                              |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/11/83</b> , 19 <b>83</b> , to <b>7/30</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>7/23</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                              |  |  |
| 22b. SIGNATURE<br><b>Kendall Faulkner MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |                              | 22c. DATE SIGNED<br><b>7/30/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kendall Faulkner MD</b>   |  |  |  | 22e. ADDRESS<br><b>STELLA MARIS - DULANEY VALLEY ROAD</b>   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>8/2/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cent.</b>  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 1 1984</b>  |                              |  |  |
| ADDRESS<br><b>6500 York Rd.</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |                              |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

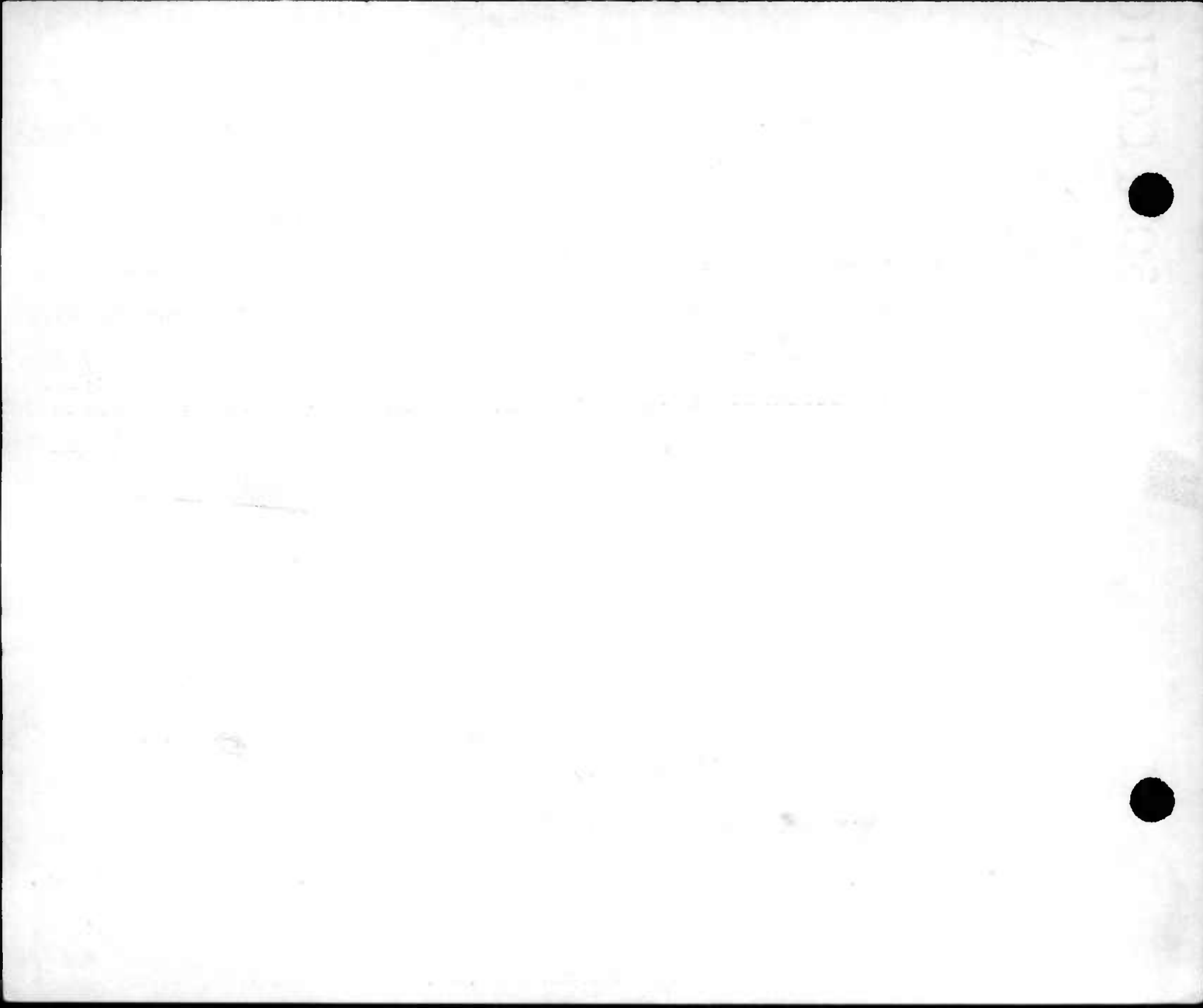
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 84 17993  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Margaret W. Besnoska   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 6, 1984                       |  |  | 2b. HOUR<br>M   |  |
| 3 SEX<br>female  |  | 4 RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Mar 29, 1906   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br>78  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Inglenook Nursing Home |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Buyer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>clothing   |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Baltimore                                       |   | 13c. CITY OR TOWN<br>Halethorpe  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Nicholas Woynovitz   |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anna Schmidt      |   |  | 13e. STREET ADDRESS / ZIP CODE<br>4605 Linden Avenue 21227   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  |  | 16b. SOCIAL SECURITY NO.<br>216-03-3155                        |   | 17 INFORMANT ADDRESS<br>Ms. Geraldine Callahan 21227<br>1241 Seven Oak |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Stroke</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1982 |  |  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED               |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19        |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME   |  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 7-4 1984 to 7-6 1984, that (I) (we) last saw the deceased alive on above, (I) (we) had (did not) see the body after death.   |  |  |  |   |  |  |  |   |  |
| 22a. SIGNATURE <u>James McPhillips</u> DEGREE  |  |  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>9 July 84   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. James McPhillips, MD  |  |  |  |   |  | 22e. ADDRESS<br>Johnnycake & Rt. 40 Catonsville, Md.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>10 July 84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City Md.                                |   |  |
| 24 FUNERAL DIRECTOR NAME<br>Ambrose Funeral Home   |  |  |  |   |  | 24b. ADDRESS<br>1328 Sulphur Sp. Rd.   |  | 25. DATE REC'D. BY REGISTRAR<br>JUL 9 1984  |  |
| 25a. REGISTRAR'S SIGNATURE<br>Julia Davidson   |  |  |  |   |  |  |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 7 9 9 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>BIGGS IDA MARGARET BIGGS   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 16 84  |  | 2b. HOUR<br>12 05 AM   |  |
| 3 SEX<br>Female  | 4. RACE<br>white  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 30, 1890   |  | 6. AGE [IN YRS. AS LAST BIRTHDAY]<br>93 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                          |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Josephs Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dept. Store |
| 13a. STATE<br>MD   |   | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Romeo E. Biggs   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida L.   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-09-0476  |  | 17. INFORMANT<br>ADDRESS<br>Barry Lauder 317 Chimney Oak Dr. Joppa, Md. 21085        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPTIS & HEMODYNAMIC PERIPHERAL<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) VASCULAR COLLAPSE<br>DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/14 1984 to 7/16 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br>Francis X Carmody  |   | DEGREE  |  | 22c. DATE SIGNED<br>7-25-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANCIS X CARMODY MD  |   | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>July 27, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn                                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn, Balto. Co., Md.  |   | 23e. NAME OF CEMETERY OR CREMATORY  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 27 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES  
DEPARTMENT OF CHEMISTRY  
530 SOUTH EAST ASIAN AVENUE  
CHICAGO, ILLINOIS 60607  
TEL. 373-5100

RECEIVED  
JAN 10 1964  
FROM: [illegible]  
TO: [illegible]  
SUBJECT: [illegible]

[illegible handwritten notes and stamps]

FRANCIS X CARROLL, JR.  
7620 York Rd., Towson, Md. 21204  
JAN 10 1964  
[illegible]



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

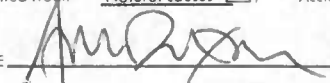
|  |                         |  |   |   |   |   |   |  |
|--|-------------------------|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JANE Elizabeth BILES</b>                         |                         |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>7 9 19 84</b> |   |   | 2b. HOUR<br><b>M</b>  |   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 30 29</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>54</b> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>7 9 19 84</b>                                  | 2d. HOUR<br><b>12:57 p.m.</b>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                           |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b> |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                         |  |   |   |   |   |   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Timonium</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Winthrop Sargent Fullerton</b>                |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Loretta Montgomery</b>  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>         |                         | 16b. SOCIAL SECURITY NO.<br><b>201-22-2754</b>   |   | 17. INFORMANT ADDRESS<br><b>Jeffrey H. Biles, 5791 Sunset View Ln.</b>  |   |   |   |  |

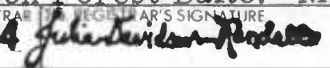
|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anasarca</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>21701</b> |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|  |   |   |
|--|---|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

|   |   |                               |
|---|---|-------------------------------|
| ACTUAL SIGNATURE<br> | TITLE (SPECIFY)<br><b>Assistant</b>               | DATE SIGNED<br><b>7-10-84</b> |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b> |                               |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>7/13/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veterans Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Garrison Forest Balto. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Martin D. Lawson</b>   |                             | 25a. DATE RECD. BY REGISTRAR<br><b>JUL 11 1984</b>             |   |
| 25b. REGISTRAR'S SIGNATURE<br> |                             |  |   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN YOUR OFFICE AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



DATE: 1951 11 22

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

107-1-101 [illegible]

107-1-101



JUL 11 1951

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE  
EXECUTED THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM" 1. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

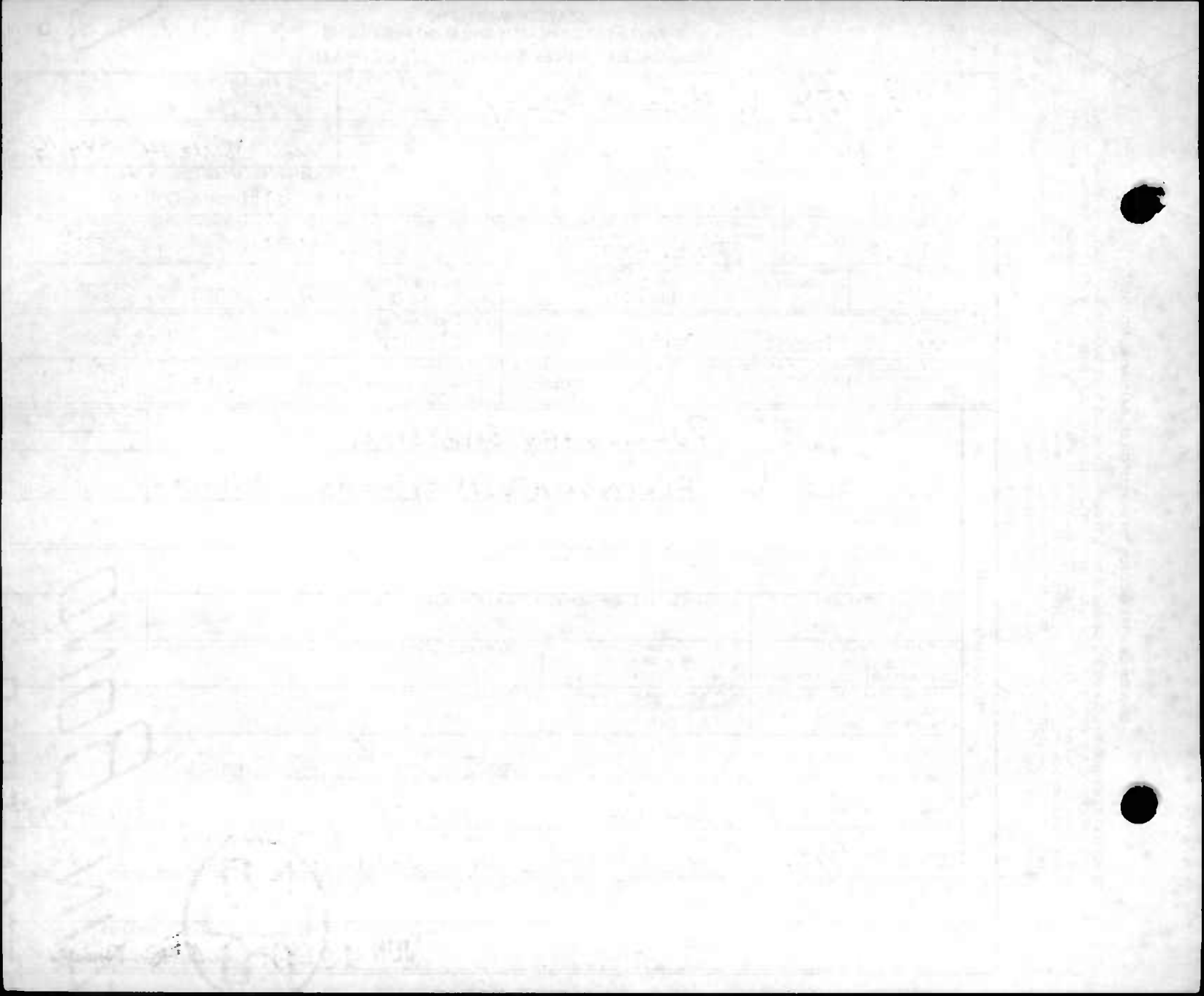
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                  |   |  |  |   |  |  |   |  |  |  |  |  |
|---|------------------|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |                  | 2. DECEASED NAME (TYPE OR PRINT) <b>BETTY P. BILLINGSLEY</b>  |  |  |   |  |  |   |  |  |  | 2b. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 19 <input type="checkbox"/> M |  |
| 3. SEX <b>F</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH MONTH <b>2</b> DAY <b>23</b> YEAR <b>17</b>  | 6. AGE (IN YEARS) (LAST BIRTHDAY) <b>67</b> YRS. | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD <b>JUNE 14</b> 19 <b>84</b> AM                                      |  | 2d. MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> |  | 2e. HOUR <input type="checkbox"/>            |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD                              |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3737 E. Joppa Road</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Receptionist</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>   |  |  |  |  |  |
| 13a. STATE <b>Md.</b>   |                  | 13b. COUNTY <b>Balto.</b>   |  | 13c. CITY OR TOWN <b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>3737 E. Joppa Rd. 21236</b>  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>Harry</b> MIDDLE <b>Vincent</b> LAST <b>Parks</b>  |                  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Eleanor</b> MIDDLE <b>Wooten</b> LAST <b>Wooten</b>  |   |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |                  | 16b. SOCIAL SECURITY NO. <b>180-03-6730</b>   |  | 17. INFORMANT <b>Mrs. Betty Brown</b>  |   | ADDRESS <b>21419 York Rd. Md. Line, Md.</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause primary for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMATOSIS - BREAST PRIMARY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |                  |   |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                  |   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |   |  |  |   |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Paul F Gverin</b>   |                  | TITLE (SPECIFY) <b>DEPUTY</b>   |  | MEDICAL EXAMINER   |   | DATE SIGNED <b>JUNE 14, 1984</b>   |  |   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>PAUL F GVERIN</b>  |                  | ADDRESS <b>1311 WESTERN RUN RD COCKEYSVILLE MD 21036</b>  |  |  |   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>  |                  | 23b. DATE <b>6/14/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>   |                  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Jelia Davidson-Randall</b>                                     |  |   |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.

## MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH |  |  |  | 84 17997   |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2r. DATE OF DEATH  |  |  |  | 3. SEX   |  |  |  |
| Emme L. Billingsley   |  |  |  | July 2 1890  |  |  |  | Females  |  |  |  |
| 4. RACE   |  |  |  | 5. DATE OF BIRTH   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |  |
| White   |  |  |  | Oct 20 1890  |  |  |  | 93 YRS   |  |  |  |
| 7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| Maryland  |  |  |  | U.S.A.   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                              |  |  |  | 12a. USUAL OCCUPATION  |  |  |  |
| Glen Arm  |  |  |  | 5470 Hill-Rose Road  |  |  |  | AT Home  |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN  |  |  |  |
| Maryland  |  |  |  | Baltimore  |  |  |  | Glen Arm   |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| B. BOARD  |  |  |  | E. LABETH  |  |  |  | 217 09 0986  |  |  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |  |  | 17. INFORMANT  |  |  |  | 17b. ADDRESS   |  |  |  |
| No  |  |  |  | Family Records   |  |  |  | W. R. S. 16  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Myocardial Insufficiency  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema  |  |  |  |  |  |  |  |  |  | 30 yrs   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchitis   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |  |  |  | 21c. HOW INJURY OCCURRED   |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  | [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY   |  |  |  | 21f. LOCATION  |  |  |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]                                       |  |  |  | CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19 62 to July 19 84, that (I) (we) last saw the deceased alive on June 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |  |  |
| William G. Tyson  |  |  |  | M.D.   |  |  |  | 7-2-84   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| Wm. A. Tyson  |  |  |  | Box 158 Kingsville Md. 21087   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |
| Burial  |  |  |  | July 4 1984  |  |  |  | Waugh Chaps  |  |  |  |
| 23d. LOCATION   |  |  |  | 23e. DATE REC'D. BY REGISTRAR  |  |  |  | 23f. REGISTRAR'S SIGNATURE   |  |  |  |
| Glen Arm Baltimore Maryland   |  |  |  | 1111 11 1984   |  |  |  | Julia Davidson-Randall   |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 24b. ADDRESS   |  |  |  | 24c. DATE REC'D. BY REGISTRAR  |  |  |  |
| NAME  |  |  |  | 8800   |  |  |  |  |  |  |  |
| Evang Chapel of Mmorus Harford Road   |  |  |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 17998

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |                     |   |   |  |   |
|---|---------------------|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>AMBROSE BINDA</b>  |                     |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 28 1984</b>  |  | 2b. HOUR<br><b>5:35A</b>  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 24 07</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>7-7</b>  |   |
| 7a. BIRTHPLACE (STATE OR DESIGN)<br><b>Pa.</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE WORK FOR MOST OF WORKING LIFE)<br><b>Retiree</b>      |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MD</b>   |                     | 13c. CITY OR TOWN<br><b>BALTIMORE TOWSON</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS / ZIP CODE<br><b>111 West. Rd. 21204</b>                         |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mr. Binda</b>  |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>1424 Hueser St.</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |                     | 16b. SOCIAL SECURITY NO.<br><b>190-05-9165</b>  | 17. INFORMANT<br>ADDRESS<br><b>1424 Hueser St.</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Bypass Surgery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis, Heart + Vascular</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pericarditis</b>   |                     |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>4 days</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |                     |   |   |  |   |
| 19a. DATE OF OPERATION  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-28-</b> 19 <b>84</b> , to <b>7-28-</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7-28-</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                     |   |   |  |   |
| 22b. SIGNATURE<br><b>Barth. Kays</b>  |                     | DEGREE  |   | 22c. DATE SIGNED<br><b>7-28-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD S. KARPENIS JR. M.D.</b>  |                     | 22e. ADDRESS<br><b>107 PROFESSIONAL ARTS BLDG BALTE. MD.</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)   |                     | 23b. DATE<br><b>7/30/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gravel Ridge Cem. Park Hight Ave.</b>  |  | 23d. LOCATION<br>(CITY OR TOWN COUNTY STATE)<br><b>BALTIMORE MD</b>   |
| 24. DECEASED DIRECTOR<br><b>Charles L. Steiner</b>  |                     | 25. DATE REC'D. BY REGISTRAR<br><b>JUL 30 1984</b>  |   |  |   |
| 26. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>  |                     | 27. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>  |   |  |   |





James  
Co.

To Cash

and Baltimore II

Mr.  
J. H. White

190-02-9102  
1494-1495

James  
Co.  
190-02-9102  
1494-1495



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 17999

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |                             |  |
|---|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ambrose L. Black</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 29, 1984</b> |  | 2b. HOUR<br><b>10:45 AM</b> |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 10, 1902</b>   |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81 YRS</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>10:45</b>  |   | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>10:45</b>   |                             |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 13. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |   |  |                             |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>BALTO.</b>   |  | 15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Villa Nsg Center</b> |   | 16. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>   |                             |  |
| 17. KIND OF BUSINESS OR INDUSTRY<br><b>Tobacco factory</b>  |  | 18. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 19. STREET ADDRESS<br><b>21229 321 Mount Holly Street</b>  |                             |  |
| 20. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ferdinand (Ferdinand) Black</b>  |  | 21. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Killester Lindsey (Lindsay)</b>  |   |  |                             |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  |  | 23. SOCIAL SECURITY NO.<br><b>11-42-10-43</b>  |   | 24. INFORMANT<br><b>Killester Jenkins</b>  |                             |  |
| 25. ADDRESS<br><b>321 Mount Holly St.</b>   |  |  |   |  |                             |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Asphyxiation</b>   |  |  |   |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ASCVD</b>   |  |  |   |  |                             |  |
| 26. DATE OF OPERATION   |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 28. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             |  |
| 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |  |                             |  |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 31. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7/29 1984</b>   |   | 32. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                             |  |
| 33. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 34. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 35. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |
| 36. I certify that (I) (this hospital) attended the deceased from <b>7/29</b> 19 <b>84</b> to <b>7/29</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/29</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two doctors did not view the body after death.) |  |  |   |  |                             |  |
| 37. SIGNATURE<br><b>Wm. D. Grayoso</b>  |  | 38. DEGREE<br><b>M.D.</b>  |   | 39. DATE SIGNED<br><b>7/30/84</b>  |                             |  |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm. D. Grayoso</b>   |  | 41. ADDRESS<br><b>5411 Old Frederick Rd. Balto. Md. 21229</b>  |   |  |                             |  |
| 42. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 43. DATE<br><b>8/3/84</b>  |   | 44. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>   |                             |  |
| 45. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C March F/H Inc.</b>   |  | 46. ADDRESS<br><b>1101 E North Avenue</b>  |   | 47. DATE REC'D. BY REGISTRAR<br><b>JUL 31 1984</b>   |                             |  |
| 48. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |   |  |                             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_



10:15  
May 20, 1964

Black

1-10-64

Male

Black

August 10, 1963

61

Paterson County

U.S.A.

Carolina

Frederick William Lee Center

Black River

221 Mount John Street

White City

Maryland

Black

Black

Black

Black

Black

Yes

11-10-64



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR XC4999776  |  |  |  | 7 4 1 8 0 0 0   |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>LAWRENCE ROBERT BLANEY  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JULY 10, 1984   |  | 2b. HOUR<br>1:35 A.M.   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>SEPTEMBER 18, 1923  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WEST VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>V.A. MEDICAL CENTER |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>IRON WORKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>LAWRENCE   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mamie Williams   |  | 13e. STREET ADDRESS / ZIP CODE<br>4315 WILKINS AVENUE / 21229   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. II 235 22 4313   |  | 17. INFORMANT ADDRESS<br>CLINICAL RECORDS, VAMC, FORT HOWARD, MD  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC ENCEPHALOPATHY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>HEMOCHROMATOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>HEPATOCELLULAR CARCINOMA, RIGHT LOBE</u> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>CONGESTIVE HEART FAILURE</u>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (he/she) attended the deceased from <u>JUNE 20, 19 84</u> to <u>JULY 10, 19 84</u> that (he/she) lost saw the deceased <u>above</u> (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Nara Simhan   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>JULY 10, 1984   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NARA SIMHAN, M.D.  |  | 22e. ADDRESS<br>VA MEDICAL CENTER, FORT HOWARD, MD 21052   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>7/13/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorset, Maryland  |  |
| 24. FUNERAL DIRECTOR NAME<br>Ambrose, Inc.  |  | ADDRESS<br>1328 Sulphur Spring Rd.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 11 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John H. Anderson  |  |

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 0 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |   |   |  |  |
|---|--|---|---|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ADAM BOKSZ   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 26, 1984              |   |   | 2b. HOUR<br>M.  |   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 22, 1914   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>21234  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1754 Weston Avenue 21234 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Turbine Engineer  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel  |   |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>21234  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>1754 Weston Avenue 21234   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Kazimir Bokszy  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Mazalewski  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. II 214-01-6317  |   | 17. INFORMANT<br>ADDRESS<br>Mary Bokszy 1754 Weston Ave. 21234  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs</u> |  |   |   |   |   |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |   |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19        |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/27/84</u> to <u>7/26</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |   |   |  |  |
| 22b. SIGNATURE<br><u>David Goldschner MD</u>  |  |   |   |   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>7/27/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GOLDSCHNER   |  |   |   |   |   | 22e. ADDRESS<br>Good Samaritan Hospital   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>July 30, 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Stanislaus Cemetery |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson  |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Jana Davidson-Randall</u>   |  |
| ADDRESS<br>8521 Loch Raven Blvd.  |  |   |   |   |   | JUL 27 1984   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Page 1

THE UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

INVESTIGATION OF THE ACTS OF VIOLENCE

1968

AND THE DESTRUCTION OF PROPERTY

IN THE CITY OF NEW YORK

AND IN THE STATE OF NEW YORK

AND IN THE DISTRICT OF COLUMBIA

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418002

1 - FOR  
STATE  
REGISTRAR

REG. NO.

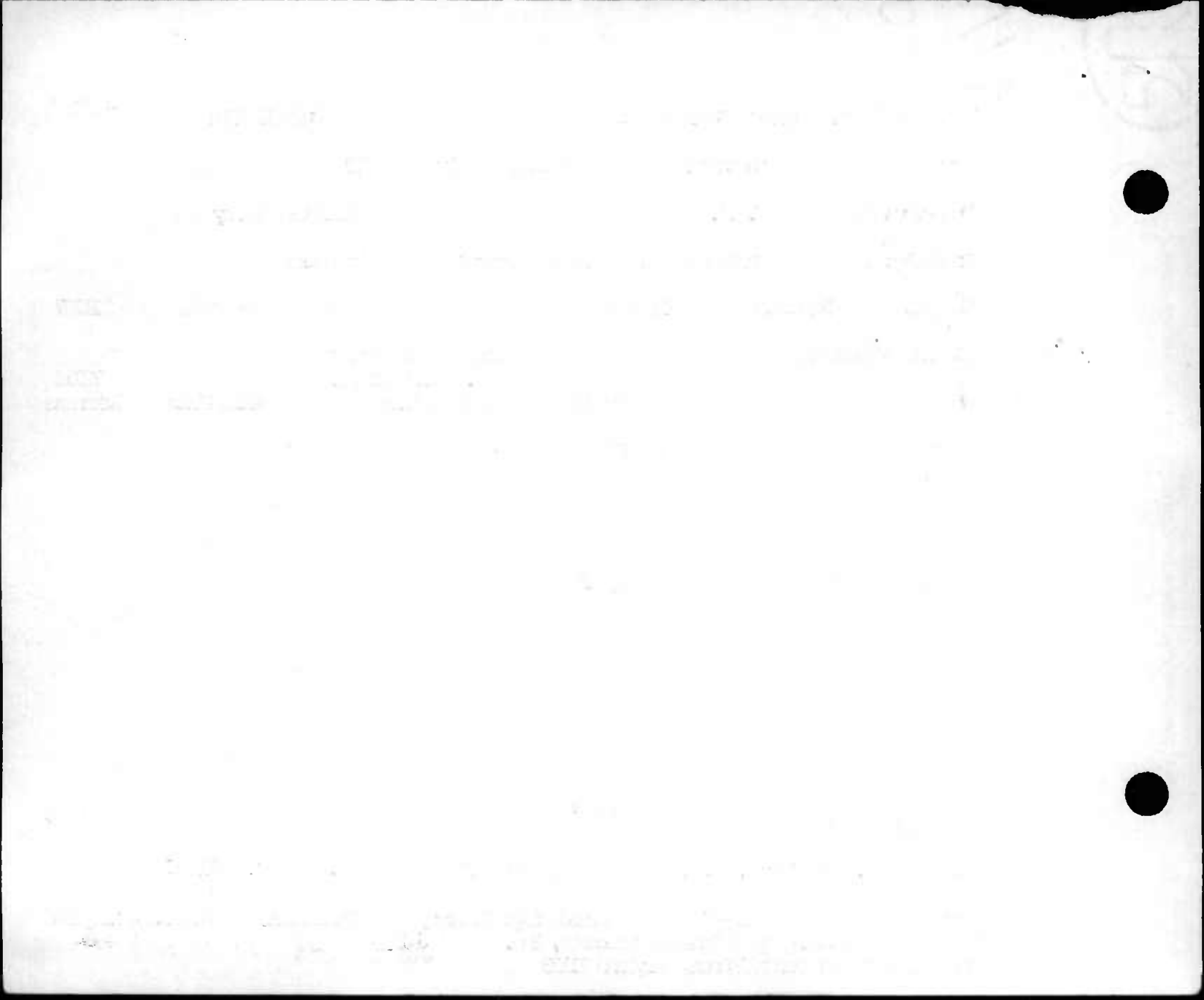
|  |  |   |   |   |  |  |   |  |   |  |
|--|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mrs. Agnes Borchart</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 19 1984</b>                |   |  | 2b. HOUR<br><b>6:00 A.M.</b>   |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 19 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8333 Merryview Drive 21207</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Valentine</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Stella Mae Lerner</b> |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   |  | 16b. SOCIAL SECURITY NO.<br><b>233-01-9037 D</b>                    |  |
| 17. INFORMANT<br>NAME ADDRESS<br><b>Mrs. Yvonne Bingham #1 Pratt Lane Bella Vista Arkansas 72714</b>   |  |   |   |   |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Diabetes mellitus</u>   |  |   |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                          |  |   |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Jerome M. Ginsberg</u>  |  |   |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7/19/84</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jerome M. Ginsberg, M.D.</b>   |  |   |   |   |  | 22e. ADDRESS<br><b>5310 Old Court Rd. Rand. 21133</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>7-23-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Baltimore Maryland</b>              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b><br><b>8728 Liberty Road Randallstown, Maryland 21133</b>   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH : 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                 |  |   |   |  |   |                                      |  |   | REG. NO. 1 8 0 0 3                           |  |
|--|-----------------|--|---|---|--|---|--------------------------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>CHARLES C. BORMAN   |                 |  |   |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED MONTH DAY YEAR<br>7-8-84 19                                |                                      |  | 2b. HOUR<br>M   |  |  |
| 3 SEX<br>MALE  | 4 RACE<br>WHITE | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09 06 20   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>63 YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |                                      | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>7-8-84 19                  |   | 2d. HOUR<br>11:30 PM                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |                                      |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. HIGHLANDS  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3852 McDowell Lane |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ORDINANCE MAN                  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. ARMY                           |   |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                 |  |   |   |  |   |                                      |  |   |  |  |
| 13a. STATE<br>MARYLAND   |                 | 13b. COUNTY<br>BALTIMORE   |   | 13c. CITY OR TOWN<br>BALTO. HGLDS.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      | 13e. STREET ADDRESS<br>3852 McDOWELL LANE, 21227                         |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HOWARD BORMAN  |                 |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELIZABETH BEANER   |  |   |                                      |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II, 46-49 |   | 17. INFORMANT<br>BENJAMIN JONES                  |   | ADDRESS<br>3852 McDOWELL LANE, 21227 |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                 |  |   |   |  |   |                                      |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                 |  |   |   |  |   |                                      |  |   |  |  |
| 19a. DATE OF OPERATION   |                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                       |   |  |   |                                      |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                      |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)             |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                 |  |   |   |  |   |                                      |  |   |  |  |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i>  |                 |  |   |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |                                      |  | MEDICAL EXAMINER  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Dennis F. Smyth, M.D.   |                 |  |   |   |  | ADDRESS<br>111 Penn Street  |                                      |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |                 |  | 23b. DATE<br>07-11-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL |   |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BROOKLYN PK. A.A. MARYLAND |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229   |                 |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 11 1984  |                                      | 25b. REGISTRAR'S SIGNATURE<br><i>W. Davidson Randle</i>                  |   |  |  |

CHRYSLER CREDIT  
FINANCIAL CORPORATION, HAS A 10 PERCENT  
INTEREST IN THE COMPANY.

JUL 1 1984

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |        |                     |  |                |                  |   |  |  |                                      |  |  |                                |  |  |
|--|--------|---------------------|--|----------------|------------------|---|--|--|--------------------------------------|--|--|--------------------------------|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)           |        |                     | 2a. DATE KNOWN<br>OF DEATH   |                |                  | 2b. DATE KNOWN<br>OF DEATH  |  |  | 2c. DATE<br>PRONOUNCED<br>DEAD       |  |  | 2d. DATE<br>PRONOUNCED<br>DEAD |  |  |
| CHARLES Russell BOSLEY                       |        |                     | 7 MONTH 7 DAY 30 YEAR 1984   |                |                  | 7 MONTH 7 DAY 30 YEAR 1984  |  |  | 7 MONTH 7 DAY 30 YEAR 1984           |  |  | 7 MONTH 7 DAY 30 YEAR 1984     |  |  |
| 3 SEX  | 4 RACE | 5 DATE OF BIRTH     | 6 AGE (IN YEARS)   | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE<br>PRONOUNCED<br>DEAD  |  |  | 7d. DATE<br>PRONOUNCED<br>DEAD       |  |  | 7e. DATE<br>PRONOUNCED<br>DEAD |  |  |
| Male   | White  | 3 MONTH 26 DAY 1917 | 67 YRS   |                |                  | 7c. DATE<br>PRONOUNCED<br>DEAD  |  |  | 7d. DATE<br>PRONOUNCED<br>DEAD       |  |  | 7e. DATE<br>PRONOUNCED<br>DEAD |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY) |        |                     | 7b. CITIZEN OF WHAT COUNTRY?   |                |                  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>     |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |                                |  |  |
| Maryland                                     |        |                     | U. S. A.   |                |                  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | Baltimore County                     |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH                    |        |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)              |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |  |                                |  |  |
| Reisterstown                                 |        |                     | Old Westminster Pike   |                |                  | Foreman   |  |  | Construction                         |  |  |                                |  |  |

|  |             |   |   |
|--|-------------|---|---|
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |             |   |   |
| 13a. STATE   | 13b. COUNTY | 13c. CITY OR TOWN                         | 13d. INSIDE CITY LIMITS?  |
| Maryland   | Baltimore   | Reisterstown                              | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME   |             | 15. MOTHER'S MAIDEN NAME                  |   |
| Theodore R. Bosley   |             | Florence Sherfey                          |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)                   |             | 16b. SOCIAL SECURITY NO.                  |   |
| Yes W.W. II  |             | 070-01-0684                               |   |
| 17. INFORMANT  |             | 315 Wembley Rd.<br>Reisterstown Md. 21136 |   |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:   |  |   |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease               |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
| (b)   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
| (c)   |  |   |  |

|   |  |  |  |
|---|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |  |
|   |  |  |  |
| 20 AUTOPSY?   |  |  |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS   |  | 21b. TIME OF INJURY  |  |
| UNDERLYING <input type="checkbox"/> OR  |  | HOUR A.M. MONTH DAY YEAR                                       |  |
| CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | P.M. 19  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   |  | 21f. LOCATION  |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | CITY OR TOWN COUNTY STATE                                      |  |

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 22a. I certify that I took charge of the remains described above, held an |  |  |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |  |  |
| death resulted from   |  |  |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |
| ACTUAL SIGNATURE  |  |  |  | TITLE (SPECIFY)  |  |  |  |
| Ann M. Dixon, M.D.  |  |  |  | Assistant MEDICAL EXAMINER   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |  |  | DATE SIGNED 7-30-84  |  |  |  |
| ADDRESS   |  |  |  | 111 Penn St., Balto., Md. 21201  |  |  |  |

|  |  |           |  |                                    |  |                          |  |
|--|--|-----------|--|------------------------------------|--|--------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION            |  |
| Burial                                       |  | 8/2/84    |  | Druid Ridge Cem.                   |  | Pikesville Baltimore Md. |  |
| 24. FUNERAL DIRECTOR                         |  |           |  | 25a. DATE REC'D. BY REGISTRAR      |  |                          |  |
| Eckhardt Funeral Chapel                      |  |           |  | AUG 3 1984                         |  |                          |  |
| ADDRESS                                      |  |           |  | 25b. REGISTRAR'S SIGNATURE         |  |                          |  |
| Owings Mills, Md. 21117                      |  |           |  | Jana Davidson-Rendell              |  |                          |  |

1. Name: [illegible]  
 2. Address: [illegible]  
 3. City: [illegible]  
 4. State: [illegible]  
 5. Zip: [illegible]  
 6. Telephone: [illegible]  
 7. Occupation: [illegible]  
 8. Date of Birth: [illegible]  
 9. Sex: [illegible]  
 10. Marital Status: [illegible]  
 11. Education: [illegible]  
 12. Employment: [illegible]  
 13. Income: [illegible]  
 14. Assets: [illegible]  
 15. Liabilities: [illegible]  
 16. References: [illegible]  
 17. Comments: [illegible]  
 18. Signature: [illegible]  
 19. Date: [illegible]

20. [illegible]  
 21. [illegible]  
 22. [illegible]  
 23. [illegible]  
 24. [illegible]  
 25. [illegible]  
 26. [illegible]  
 27. [illegible]  
 28. [illegible]  
 29. [illegible]  
 30. [illegible]  
 31. [illegible]  
 32. [illegible]  
 33. [illegible]  
 34. [illegible]  
 35. [illegible]  
 36. [illegible]  
 37. [illegible]  
 38. [illegible]  
 39. [illegible]  
 40. [illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |   |  |  |                                   |   |  |
|--|--|--|---|---|--|---|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James BOULDIN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 23, 1984</b> |   |  | 2b. HOUR<br>am<br><b>10:14</b>  |  |  |                                   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 21 01</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |                                   | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |  |   |  |  |                                   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1130 Abbott Court 21202</b>   |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Bouldin</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estella</b>   |  |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-10-93684</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mary Bouldin 1130 Abbott Court</b>                               |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b>   |  |  |   |   |  |   |  |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>DIABETIC HYPEROSMOLAR COMA</b>   |  |  |   |   |  |   |  |  |                                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF:<br>(c)   |  |  |   |   |  |   |  |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |  |   |   |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JULY 22</b> , 19 <b>84</b> , to <b>JULY 23</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>JULY 23</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death. |  |  |   |   |  |   |  |  |                                   |   |  |
| 22b. SIGNATURE<br><i>L. Villalobos</i>   |  |  |   | DEGREE<br><b>M.D.</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED<br><b>7/23/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. VILLALOBOS, M. D.</b>   |  |  |   | 22e. ADDRESS<br><b>9000 FRANKLIN SQUARE DR., 21237</b>  |  |   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  |  |   | 23b. DATE<br><b>7/27/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |  |   |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 23 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Hendall</i>   |                                   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1. FOR STATE REGISTRAR  |  | HELEN C. BOWERMAN  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8418006   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME  |  |  |  | 2a. DATE OF DEATH  |  |   |  |
| FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR HOUR  |  |   |  |
| Helen C. BOWERMAN   |  |  |  | July 15, 1984 12:45a M   |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE  |  |
| FEMALE  |  | WHITE  |  | MONTH DAY YEAR<br>4 26 07  |  | 77 YRS  |  |
| 7a. BIRTHPLACE  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| MARYLAND  |  | USA  |  |  |  | Baltimore County MD   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                                      |  |  |  | 12a. USUAL OCCUPATION   |  |
| ROSSVILLE   |  | FRANKLIN SQUARE HOSPITAL   |  |  |  | CLERK   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |   |  |
| GROCERY   |  |  |  |  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| MD  |  | BALTO  |  | WHITE MARSH  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS / ZIP CODE   |  |   |  |
| JOHN  |  | HELEN  |  | 11009 BOWERMAN RD 21162  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |
| NO  |  | 215092224  |  | ROBERT A. JOHNSTON 11021 BOWERMAN RD   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) Cardiac Arrest  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |
| (b) Probable Sepsis   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |
| (c)   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |   |  |
|   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from July 14, 1984, to July 15, 1984, that (we) last saw the deceased alive on July 15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Stephen F. Hickey   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br>7-15-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stephen Hickey, M.D.   |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| BURIAL  |  | 7/18/1984  |  | LOUDON PARK  |  | BALTO COUNTY MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  |  | 25. DATE REC'D. BY REGISTRAR   |  | 26. REGISTRAR'S SIGNATURE   |  |
| J. H. Hickey  |  |  |  | JUL 16 1984  |  | John Davidson-Randall   |  |

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

84

18007

 1 - FOR  
 STATE  
 REGISTRAR

REG. NO.

|  |  |  |   |   |                             |  |  |
|--|--|--|---|---|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELLEN C Bowler</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 25 1984</b> |   | 2b. HOUR<br><b>11:40 PM</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 27 1900</b>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>84</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mass.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accounting Clerk</b>   |                             | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Randallstown</b>  |                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>3701 Hamor Ct 21133</b>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Bowler</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Scanlon</b>  |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>013-07-7567A</b>   |   | 17. INFORMANT<br><b>Miss. Margaret Sullivan</b>   |                             | 3701 Hamor Court Randallstown, MD. 21133   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7-25-84</b><br><b>7-03-84</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |                             |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-03</b> , 19 <b>84</b> , to <b>7-25-84</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7-25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |  |  |   |   |                             |  |  |
| 22b. SIGNATURE<br><b>Allen J. Chircus M.D.</b>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                             | 22c. DATE SIGNED<br><b>7-25-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allen J. Chircus M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>32 Stock Mill Rd. Pikesville 21208</b>   |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/28/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Michaels Cem.</b>  |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Springfield Hampden, Mass.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD. 21133</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 30 1984</b>   |                             |  |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Randall</b>   |                             |  |  |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 0 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |   |  |   |  |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James T. Bowling                    |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 8, 1984 |   |  | 2b. HOUR<br>11:30 <sup>a</sup> AM   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 25, 1901  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Parkton                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>17330 Bushland Road |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lt. Cmdr.                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Maritime Service |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Parkton  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>17330 Bushland Road            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Arthur C. Bowling                |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Richardson  |  |   |  | ADDRESS<br>17330 Bushland Rd.                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>217-01-6623  |   | 17. INFORMANT<br>Nellie E. Bowling  |  | ADDRESS<br>Parkton, MD 21120  |  |   |  |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic Ca. bladder</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

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| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 1981</u> to <u>Now</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>in April</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Pietr Hitzig</u>  |  |   |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7/9/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Pietr Hitzig  |  |   |  | 22e. ADDRESS<br>300 E Joppa, Towson  |  |  |  |

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| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                     |  | 23b. DATE<br>7-11-1984 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Carmel Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkton, Balto., MD 21120 |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>J. J. Hartenstein</u> ADDRESS <u>New Freedom, PA 17349</u> |  |                        |  | 25. DATE RECEIVED BY REGISTRAR <u>JUL 12 1984</u> REGISTRAR'S SIGNATURE <u>J. J. Hartenstein</u> |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                            |  |  |  |  |
|---|--|---|---|---|----------------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Beatrice M. Bradley</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 13, 1984</b> |   | 2b. HOUR<br>M<br><b>AM</b> |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 21, 1896</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Missouri</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Valley Nursing Center</b> |   |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Artist</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            | 13e. STREET ADDRESS / ZIP CODE<br><b>6752 Glenkirk Road 21239</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Homer B. Moore</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Glaze</b>  |   |   |                            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>370-14-4300</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Miriam S. Keyser 6752 Glenkirk Rd. 21239</b>   |   |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cerebrovascular Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |                            |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |                            |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                            |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-11-84</b> to <b>7-13-84</b> , that (I) (we) lost saw the deceased alive on <b>7-11-84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |   |   |                            |  |  |  |  |
| 22b. SIGNATURE<br><b>Marion C. Kowalewski</b>   |  |   |   | DEGREE<br><b>MD</b>   |                            | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7-13-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marion C. Kowalewski, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>8604 Harford Road Baltimore, Md. 21234</b>   |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>July 14, 1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Park</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 16 1984</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Randall</b>  |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (see page 3).

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|---|--|--|---|---|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EUGENE BRIGHT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 24 84</b> |   | 2b. HOUR<br><b>7 40 A M</b> |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 17 21</b>  |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |                             |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |   |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO 21234</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Valley View Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborter</b>             |                             |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STREET ADDRESS<br><b>8720 Emge Rd.</b>  |   | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |   |   |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>IL 1942-44 251-20-9936</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Valley View Nursing Home 8720 Emge Rd.</b>                       |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Seizures</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Organic Brain Sd</b> |  |  |   |   |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                             |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                             |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21c. LOCATION<br>CITY OR TOWN COUNTY STATE  |                             |  |
| 22a. I certify that (I) this physician attended the deceased from <b>3/1/83</b> to <b>7/24/84</b> that (I) (we) last saw the deceased alive on <b>7/19/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we did not) view the body after death.   |  |  |   |   |                             |  |
| 22b. SIGNATURE<br><b>Nguyen</b>   |  | DEGREE   |   | 22c. DATES SIGNED<br><b>7/25/84</b>   |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Vuore NGUYEN</b>  |  | 22e. ADDRESS<br><b>6331 Belair Rd Balto Md 21206</b>   |   |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>7/27/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CROWNSVILLE VA.</b>                                    |                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CROWNSVILLE Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. Brown Comm F/H 1206-1208 W. NORTH AVE</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1984</b>   |                             |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |   |   |                             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

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REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 18, 1902

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS  
1902



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 1 1

 1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |                                    |  |
|--|--|--|--|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Eleanor Bronson</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Thursday 7 19 84</b> |  | 2b. HOUR<br>MIN.<br><b>6 15 PM</b> |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 28 1917</b>                               |                                    |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>67</b>   |  | 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>PA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                    |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.   |  |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson Md</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Towson Convalescent Home</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |                                    |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Phos. Skelly Co.</b>   |  | 13a. STREET ADDRESS<br><b>234 Kershaw Ct. Joppa, Md.</b>   |  |  |                                    |  |
| 13b. STATE<br><b>MARYLAND</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur Kretzschmar</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha I. Ringeling</b>  |  |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>198-01-4155</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Arthur W. Kretzschmar 234 Kershaw Ct. 21085</b>       |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulm arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>OLD CVA - Decubitus Ulcers hips</b> |  |  |  |  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>OLD CVA - Decubitus Ulcers hips</b>   |  |  |  |  |                                    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                    |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                                    |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |                                    |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>9/11 19 80</b> to <b>7/19 19 84</b> , that (I) (we) last saw the deceased alive on <b>7/17 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.) |  |  |                                    |  |
| 22b. SIGNATURE<br><b>Richard Maffezzoli</b>  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>7/26/84</b>   |                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD MAFFEZZOLI</b>   |  | 22e. ADDRESS<br><b>660 KENILWORTH DR. TOWSON, MD. 21204</b>  |  |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7-25-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westminster Cem.</b>                        |                                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>W. Conchokin, Tenn.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1984</b>  |  |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Kretzschmar</b>  |  | 25c. REGISTRAR'S SIGNATURE<br><b>Randall</b>   |                                    |  |

3. 1941-1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 is marked, any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |                     |   |  |  |  |   |  |
|--|--|---|--|---|---------------------|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothy Elsie Brookes   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 30, 1984 |   | 2b. HOUR<br>9:25 pm |   |  |  |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 21, 1899   |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | 8. UNDER 74 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Heritage Meridian Nursing Home |  |   |                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housekeeper                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Residential   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk  |                     | 13e. STREET ADDRESS / ZIP CODE<br>4 Arrowship 21222   |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Brookes  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Phoebe Am Sharratt   |                     |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-34-8900  |  | 17. INFORMANT<br>Charles B. Brookes 86 Northship Rd. 21222  |                     |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardio Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |                     |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>DAY<br>YEARS- |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a:<br><u>GANGRENE (L) Foot</u>   |  |   |  |   |                     |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><u>6/21/84</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>GANGRENE</u>   |  |   |                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                     |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                     |   |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 31, 1984</u> to <u>July 30, 1984</u> , that (I) (we) last saw the deceased alive on <u>July 30, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                     |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>B.C. Veneracion Jr.</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                     |   |  | 22c. DATE SIGNED<br><u>7/30/84</u>   |  |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B. C. Veneracion Jr., M.D.  |  |   |  | 22e. ADDRESS<br>3401 Dundalk Ave. Dundalk, MD 21222   |                     |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>08/02/1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley, Inc.  |  |   |  | ADDRESS<br>Dundalk, MD 21222  |                     |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 1 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |  |

BP.

DOWN

DOWN

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



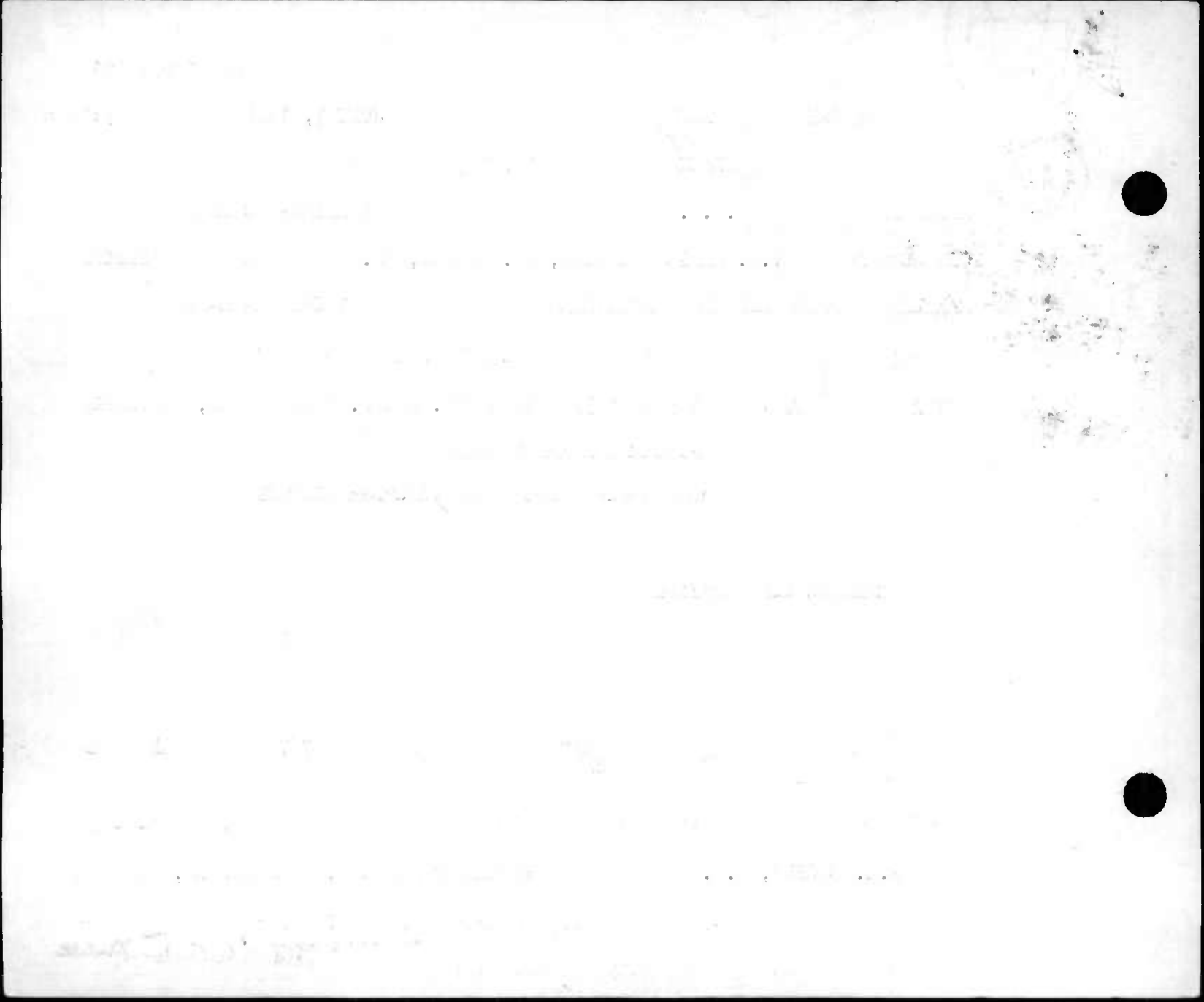
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 1 3

FOR  
1 - STATE  
REGISTRAR

REG. NO. XC 21 697 401

|  |  |  |  |  |                              |  |
|--|--|--|--|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARRY LEE BROOKS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 7, 1984</b> |  | 2b. HOUR<br><b>5:25 a.m.</b> |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 24, 1896</b>  |                              |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 8. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                              |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>V.A. MEDICAL CENTER, FT. HOWARD, MD.</b> |                              |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WAITER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>   |  | 13. STREET ADDRESS / ZIP CODE<br><b>651 COLEMAN LANE 21108</b>   |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Brooks</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Catherine Barnes</b>  |  | 16. SOCIAL SECURITY NO.<br><b>705 09 1935</b>  |                              |  |
| 17. INFORMANT<br><b>VAMC MED. RECDs. FORT HOWARD, MARYLAND</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CHRONIC RENAL FAILURE</b> |  |  |  |  |                              |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |                              |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                              |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (this hospital) attended the deceased from <b>6/29</b> 19 <b>84</b> to <b>7/7</b> 19 <b>84</b> that (we) last saw the deceased alive on <b>7/7</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |                              |  |
| 22b. SIGNATURE<br><b>Ashok Kumar Chopra</b>  |  | DEGREE<br><b>MBBS</b>  |  | 22c. DATE SIGNED<br><b>7-7-84</b>  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.K. CHOPRA, M.D.</b>  |  | 22e. ADDRESS<br><b>VA MEDICAL CENTER, FORT HOWARD, MARYLAND</b>  |  |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7-10-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>   |                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>  |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUL 11 1984 Julia Davidson-Rodell</b>  |  |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401</b>   |  |  |  |  |                              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Louise Arbia BROOKS</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 14, 1984</b>   |  | 2b. HOUR<br><b>11:00 PM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 10 24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>60</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Sp. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>   |  |
| 13a. STATE<br><b>md</b>  |  |  |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>36 AKINS Circle</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Handy JANNY</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>156-18-5354</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Clarence Brooks 2532 Coldspring Ave. LANE</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest, Pleural Effusion</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 12, 19 84</b> to <b>July 14, 19 84</b> , that (I) (we) last saw the deceased alive on <b>July 14, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Doreen E. Feldhouse</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>7/14/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Doreen E. Feldhouse, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/19/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. ZION</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. Brown</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 20 1984</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |   |  |  |  |

MEDICAL CERTIFICATION



FIBER



100%

Handwritten notes and a table. The notes include:  
- "100% of the fiber is made of..."  
- "The fiber is made of..."  
- "The fiber is made of..."  
The table has several columns and rows of handwritten data, including numbers and text.

Handwritten notes at the bottom of the page, including:  
- "100% of the fiber is made of..."  
- "The fiber is made of..."  
- "The fiber is made of..."



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 20. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  | 20. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| MILDRED E. BROWN   |  |  |  | 7 20 84 06.15 AM   |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.   |  |
| Female   |  | White  |  | 4/27/197   |  | 87  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Illinois   |  | U.S.A.   |  |  |  | Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Randlestown  |  | Baltimore County Gen.  |  | Nurse  |  | Hospital  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| Maryland   |  | Baltimore  |  | Baltimore  |  | 13e. STREET ADDRESS   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16. SOCIAL SECURITY NO.  |  |   |  |
| Arthur Kenney  |  | Frances Bliss  |  | 005-32-4629  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |
| no   |  | 005-32-4629  |  | Frances Perry 224 Tyrone Circle 21212  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute C.V.A.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>07-06-84</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>07-06-84</u>  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>July 6</u> , 19 <u>84</u> , to <u>July 20</u> , 19 <u>84</u> , that (we) last saw the deceased alive on <u>July 20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED  |  |
| Young Joon Ro  |  |  |  |  |  | July 20, 84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |
| Young Joon Ro  |  | B. C. G. H.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| Cremation  |  | 7/20/84  |  | Westview Cemetery  |  | Cationsville, Balto., Md.   |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Ambrose, Inc. 1328 Sulphur Spring Rd. 2  |  |  |  | JUL 23 1984 Julia Davidson-Rendell   |  |   |  |



EXHIBIT

2067 COLLECTION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>IRVIN F. BUCHAR</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 9 1984</b>                                       |  | 2b. HOUR<br><b>10:50 AM</b>                                      |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 15 1892</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Jeweler</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Buis.</b>            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MD</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1 E University Pkwy 21218</b>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Buchar</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-44-0470</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Laurence K. Wagner Balto., MD.</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 hr</b>   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arterio-sclerotic Cardio Vascular disease years</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |   |  |  |
| <b>Basal Cell Carcinoma of Skin</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>20 June 1984</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Low back Ulcer</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>27 June 84</b> to <b>9 July 84</b> , that (I) (we) last saw the deceased alive on <b>9 July 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Walter T. Kees MD</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>9 July 1984</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Walter T. Kees M.D.</b>   |  | 22e. ADDRESS<br><b>Monkton, Md 21111</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7-11-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co., Balto., Md.</b>   |  | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>10 10 1984</b>                                   |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418017

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rishel Harwood Buckley |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 21, 1984 |   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 9, 1908   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD. |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>529 Old Home Rd. (Residence) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant Ret.   |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |  |

|   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>529 Old Home Rd. 21206 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles H. Buckley  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertha A. Weeks        |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                       |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Army WW II 108-01-8969 |  | 17. INFORMANT<br>ADDRESS<br>Christine L. Buckley 539 Old Home Rd. 21206 |  |   |  |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Pulmonary arrest</u>           |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 hr</u> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Severe Pulmonary Emphysema</u> |  | <u>10 yrs.</u>   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Severe Osteoporosis of bones</u> |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |

|   |  |  |  |                                    |  |
|---|--|--|--|------------------------------------|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> 19 <u>76</u> , to <u>7-23</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>7/24</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |                                    |  |
| 22b. SIGNATURE<br><u>Jaime Punzalan</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>7/23/84</u> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Jaime Punzalan M.D.  |  | 22e. ADDRESS<br>5214 Harford Road Baltimore, Maryland  |  |                                    |  |

|   |  |                      |  |   |  |  |  |
|---|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                            |  | 23b. DATE<br>7/24/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leonard J. Ruck, Inc. Baltimore, Maryland |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>24 1984                |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HERMAN William Buechler</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 21, 1984</b>                      |   | 2b. HOUR<br>M<br><b>M</b>                                       |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT 19, 1928</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>500 Basley Ave APT. 2N</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>COURT</b>   |   |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>TOWSON</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>500 Basley Ave. APT. 2N</b>           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERMAN W. Buechler</b>                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>AGNES Phipps</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>          |  | 16b. SOCIAL SECURITY NO.<br><b>215-24-4725</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MARY N. Buechler 500 Basley Ave 21204</b>                        |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**MASSIVE HEMORRHAGE (GI)**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **Acute Alcohol Intake**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |

|  |                           |  |                  |
|--|---------------------------|--|------------------|
| 22b. SIGNATURE<br><i>Constantinos P. Chilimindrus</i>                        | DEGREE<br><b>MD, FACS</b> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CONSTANTINOS P. Chilimindrus</b> |                           | 22e. ADDRESS<br><b>GREATER BALTIMORE Medical Center</b>  |                  |

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>      | 23b. DATE<br><b>July 24, 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville BALTO Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HARTLEY MILLER FUNERAL HOME</b> |                                   | ADDRESS<br><b>7527 HARFORD Rd</b>                           | 25a. JUL 23 1984 BY REGISTRAR REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 1 8 0 1 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |                                   |
|---|--|---|--|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Adolph H. BUESCHER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 24, 1984</b>  |  | 2b. HOUR<br>MIN.<br><b>3:14p</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov 28, 1892</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 72 HRS.  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore county</b> MD   |  |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retire Supervisor Balt. G&amp;E</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br><b>Maryland Baltimore</b> |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 13d. STREET ADDRESS / ZIP CODE<br><b>4804 Holder Ave 21214</b> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ide Buescher</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agusta Seimes</b>   |  |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-05-3004</b>  | 17. INFORMANT<br><b>Pearl E Buescher</b>  |  | ADDRESS<br><b>Same As 13e</b>                                  |                                   |

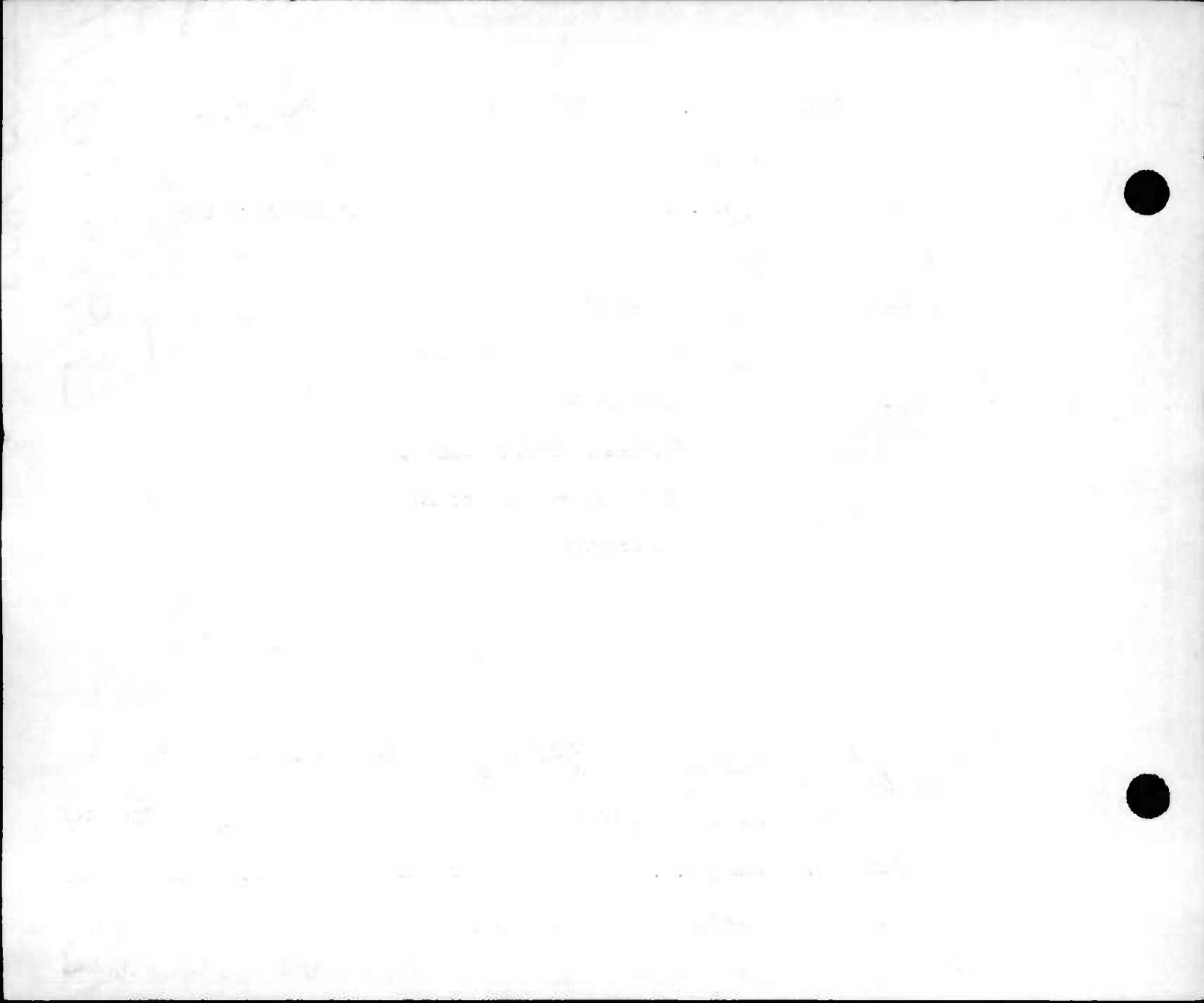
|  |                             |  |  |  |   |
|--|-----------------------------|--|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congested Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia</b>   |                             |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |                             |  |  |  |   |
| 19a. DATE OF OPERATION   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (this hospital) attended the deceased from <b>July 7</b> , 19 <b>84</b> , to <b>July 24</b> , 19 <b>84</b> , that (we) last saw the deceased alive on <b>July 24</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                             |  |  |  |   |
| 22b. SIGNATURE<br><b>Darius S. Russin MD</b>   |                             | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>7/24/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Darius S. Russin, M.D.</b>   |                             | 22e. ADDRESS<br><b>9000 Franklin Square Dri. Baltimore 21237</b>       |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>7/27/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens Of Faith</b>          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |                             | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1984</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4

1 8 0 2 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |  |  |   |  |  |
|--|--|---|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lillian M. Burke</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 29 84</b>                           |  |  | 2b. HOUR<br><b>8:30 AM</b>   |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 16 05</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |   |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Armstrong Nursing Home</b> |   |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>  |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Pre School</b>   |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. CITY OR TOWN<br><b>Baltimore</b>   |  |   | 16b. COUNTY<br><b>Baltimore</b>   |  |  | 16c. CITY OR TOWN<br><b>Baltimore</b>  |  |   | 16d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |
| 17. STREET ADDRESS / ZIP CODE<br><b>6401 Loch Raven Blvd 21239</b>   |  |   | 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. Ayres</b>                  |  |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Neuhauser</b>   |  |   | 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  |
| 21. SOCIAL SECURITY NO.<br><b>215-24-3938A</b>   |  |   | 22. INFORMANT<br>ADDRESS<br><b>Alviah V. Ayres 3233 Tyne Lane Sarasota, Fla</b> |  |  | 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Respiratory</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of Breast</b><br>APPROPRIATE INTERVAL BETWEEN CAUSE AND DEATH<br><b>2<sup>nd</sup> days</b><br><b>6<sup>th</sup> months</b><br><b>2<sup>nd</sup> years</b> |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I  |  |   |   |  |  |  |  |   |  |  |
| 24. DATE OF OPERATION  |  |   | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |  |  | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 29. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                       |  |  | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |
| 31. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 32. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |  |  | 33. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 34. I certify that (I) (the hospital) attended the deceased from <b>4 April 1984</b> to <b>28 July 1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>27 July 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (we) did) (did not) view the body after death. |  |   |   |  |  |  |  |   |  |  |
| 35. SIGNATURE<br><b>Charles J. Ruck</b>  |  |   |   |  |  | 36. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 37. DATE SIGNED<br><b>7/29/84</b>   |  |  |
| 38. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   | 39. ADDRESS   |  |  |  |  |   |  |  |
| 40. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 41. DATE<br><b>Aug. 1, 1984</b>   |  |  | 42. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  |   | 43. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                       |  |
| 44. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |  |   |   |  |  | 45. DATE REC'D. BY REGISTRAR<br>REGISTRAR'S SIGNATURE<br><b>AIIG 1 1984 Julia Davis-Randall</b>  |  |   |  |  |

BP

Leonard G. Bush, Inc. Baltimore, Maryland

Aug. 1, 1984 Parkwood Cemetery

Baltimore

Maryland

No

John

L.

Wives

Mary

Reburied

Division W. Wives 7277 Tyne Lane Baltimore, Md

Walter Home

Teacher

The School

White

U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified if one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mrs. Louise C. Burton</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 15 1984</b>  |  | 2b. HOUR<br><b>11:30 AM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 17 1892</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret - live in</b>                                   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>companion</b>  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>805 Wildwood Parkway</b>   |  | 13f. CITY OR TOWN<br><b>Baltimore</b>   |  | 13g. STATE<br><b>Maryland</b>   |  | 13h. ZIP CODE<br><b>21229</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard Owens Crusey</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ann (Stahl) Crusey</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-05-0362</b>   |  | 17. IN BALTIMORE CITY OR COUNTY?<br><b>Yes</b>  |  | 18. ADDRESS<br><b>3515 Keston Rd. Baltimore Maryland 21207</b>   |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardio-vascular disease</u>   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Arteriosclerotic Cardio-vascular disease</u>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 14, 1984</u> to <u>July 15, 1984</u> , that (I) (we) last saw the deceased alive on <u>July 15, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Sharon Pountabed</u> M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |  | 22c. DATE SIGNED<br><u>7-15-84</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>GHASSEM Pountabed</u>  |  |   |  | 22e. ADDRESS<br><u>Balto. County Gen. Hospital</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-18-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, Maryland 21133</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 18 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson-Randall</u>  |  |

BP

2005-0011

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Xavier J. Callan</b>     |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 24, 1984</b>                               |   | 2b. HOUR<br>MIN.<br><b>7:45 A<sup>M</sup></b>                    |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 - 26 - 15</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Superintendent</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>         |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |  |
| 13a. STATE<br><b>Md</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Towson</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 13e. STREET ADDRESS / ZIP CODE<br><b>500 Virginia Ave #1112 21204</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry J. Callan</b>                        |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Bender</b>                       |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>      |  | 16b. SOCIAL SECURITY NO.<br><b>WWII</b>   | 17. INFORMANT<br>ADDRESS<br><b>Christine Callan same</b>                                  |   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bullous emphysema</b>   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Pelvic abscess due to perforated diverticulum and arteriosclerotic cardiovascular disease</b>  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 7, 1984</b> , to <b>July 24, 1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>July 24, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><i>John E. Adams</i>  |  |  |  | 22c. DATE SIGNED<br><b>7/24/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John E. Adams, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>6701 N. Charles St., Baltimore MD 21204</b>                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/27/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md Vet Cemetery</b>                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee Funeral Home, 3631 Falls Road, 21211</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Garrison Forest Balto. Co. Md</b> |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 27 1984</b>                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



23-5



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |   |   |   |  |   |  |   |  |
|---|--|---|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SOLOMON</b>  |  |   | 2. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>12</b> YEAR <b>84</b>                           |   |   | 7b. HOUR<br><b>0255AM</b>  |   |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>16</b> YEAR <b>80</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>XXXXXX</b> (83)  |   | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>LITHUANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BEVERAGES</b>  |   |  |
| 13a. STATE<br><b>md</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Pikesville</b>                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>255 E. CHATSWORTH AVE. 21136</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>NISSAN</b> MIDDLE <b>CAPLAN</b> LAST <b>CAPLAN</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MOLCHA</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b> |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, IF NOT UNKNOWN) <b>NO</b>  |   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-8156</b>   |  |   | 17. INFORMANT<br><b>MRS. SANDRA SHERMAN</b>   |   |   | 259 E. CHATSWORTH AVE. REISTERSTOWN, MD  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA + SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>DEHYDRATION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>21136</b>          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |   |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                    |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7. 12. 84</b> to <b>7. 13. 84</b> , that (I) (we) lost<br>saw the deceased alive on <b>7. 12. 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                  |  |   |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>R. A. YADUR</b>  |  |   | DEGREE<br><b>MD</b>   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>7. 12. 84</b>                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. A. YADUR</b>   |  |   | 22e. ADDRESS<br><b>GOINDA RD BALTIMORE COUNTY GENL HOSPITAL</b>                           |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |   | 23b. DATE<br><b>JULY 13, 1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RIGA KURLANDER</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>                         |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 17 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

This image shows a blank, aged, cream-colored page, likely an endpaper or flyleaf from an old book. The paper has a slightly textured appearance with some minor creases and discoloration, particularly towards the edges. Two dark circular holes are visible near the right edge, possibly from a binding process. Faint, illegible markings are scattered across the page, which appear to be bleed-through from the reverse side. The page is set against a dark background.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death must be notified at once.

| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR   |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 3. SEX   |  |  |  | 4. RACE  |  |  |  | 5. DATE OF BIRTH   |  |  |  |
| 7a. BIRTHPLACE   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                   |  |  |  | 8. AGE   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION        |  |  |  | 12a. USUAL OCCUPATION  |  |  |  |
| 13a. STATE   |  |  |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN  |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME                                       |  |  |  | 16. STREET ADDRESS / ZIP CODE                                      |  |  |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |  |  | 18b. SOCIAL SECURITY NO.                                       |  |  |  | 17. INFORMANT  |  |  |  |
| 18. CAUSE OF DEATH   |  |  |  | 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  |  |  |
| 20a. AUTOPSY?  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH?       |  |  |  |
| 21b. TIME OF INJURY  |  |  |  | 21c. HOW INJURY OCCURRED                                       |  |  |  | 21d. INJURY OCCURRED   |  |  |  |
| 21e. PLACE OF INJURY   |  |  |  | 21f. LOCATION  |  |  |  | 22a. I certify that (I) (this hospital) attended the deceased from |  |  |  |
| 22b. SIGNATURE   |  |  |  | 22c. DATE SIGNED   |  |  |  | 22d. PHYSICIAN'S NAME  |  |  |  |
| 22e. ADDRESS   |  |  |  | 23a. BURIAL, CREMATION, REMOVAL                                |  |  |  | 23b. DATE  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION  |  |  |  | 24. FUNERAL DIRECTOR   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |  |  |  |  |
| MARY E. CARBAUGH   |  |  |  | JULY 5, 1984   |  |  |  | 4:55A M  |  |  |  |
| Female   |  |  |  | White  |  |  |  | 7 30 35  |  |  |  |
| Maryland   |  |  |  | USA  |  |  |  | 38 YRS.  |  |  |  |
| TOWSON   |  |  |  | SAINT JOSEPH HOSPITAL  |  |  |  | BALTIMORE CITY OR COUNTY OF DEATH                                  |  |  |  |
| Maryland   |  |  |  | Baltimore  |  |  |  | Housewife  |  |  |  |
| Patrick J. Mangan  |  |  |  | Kathline Watson  |  |  |  | 650 Park Wyrth Ave. 21218  |  |  |  |
| No   |  |  |  | 213-32-8532  |  |  |  | Mr. Charles Carbaugh 650 Park Wyrth Ave. 21218                     |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Micro angio pathic Hemolytic Anemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Adenocarcinoma of Lung - metastases</u> |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:   |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH?   |  |  |  | 21b. TIME OF INJURY  |  |  |  | 21c. HOW INJURY OCCURRED   |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY   |  |  |  | 21f. LOCATION  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  |  |  | 22b. SIGNATURE   |  |  |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME  |  |  |  | 22e. ADDRESS   |  |  |  | 23a. BURIAL, CREMATION, REMOVAL                                    |  |  |  |
| 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY                             |  |  |  | 23d. LOCATION  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| A. Alan Seitz, Jr. 3818 Roland Ave. 21211  |  |  |  | JUL 9 1984   |  |  |  | Julia Davidson-Randall   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <b>ETHEL</b> MIDDLE <b>M.</b> LAST <b>CARR</b><br><b>ETHEL CARR</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>12</b> YEAR <b>84</b>  |  | 2b. HOUR<br><b>10:15 AM</b>   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>June</b> DAY <b>4</b> YEAR <b>1897</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>87</b> RS<br>IF UNDER 1 YEAR: MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b> |   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |   |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>3104 Gartside Ave.</b>  |   |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>E.</b> LAST <b>Stewart</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lillian</b> MIDDLE <b>M.</b> LAST <b>Parks</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-1009</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Elaine C. Dixon - Same as #13e</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypotensive shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute subendocardial M.I.</b> |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>CONGESTIVE HEART FAILURE</b>  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR <b>A.M.</b> MONTH <b>DAY</b> YEAR <b>19</b><br>P.M.   |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |
| 22b. SIGNATURE<br><b>Hafeez A. Gheyli</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>7/12/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFAEEZ A GHEYLI</b>   |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN HOSP</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7-14-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium, Baltimore, Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME <b>Ruck Towson Funeral Home, Inc.</b> ADDRESS <b>1050 York Rd. Towson, Md. 21204</b>   |  |   |   |
| 25. DATE REC'D. BY REGISTRAR<br><b>JUL 17 1984</b>   |  | 26. REGISTRAR'S SIGNATURE   |  |   |   |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|  |  |  |   |  |   |
|--|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>KIT A CARTER   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 2 84   |  | 2b. HOUR<br>1:32 P.M.   |
| 3. SEX<br>FEMALE   | 4. RACE<br>BLACK   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 14 47  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>COUNTY MD.  |  |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GEN Hosp |  | 12a. USUAL OCCUPATION<br>(GIVE WORK FOR MOST OF WORKING LIFE)<br>Baltimore                      |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE   |  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>4008 Bedford Rd, MD 21207                    |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MALACH, DANKINS  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Beulah Williams   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.<br>NONE   | 17. INFORMANT<br>ADDRESS<br>Beulah Dankins 4008 Bedford Rd   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ACUTE PULMONARY EDEMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                      |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>SEVERE INFECTION PERINEAL & INNER THIGH AREA   |  |  |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>June 12 84 July 2 84      |   |
| 22. I certify that (I) (this hospital) attended the deceased from July 2 1984 to July 2 1984, that (I) (we) lost saw the deceased alive on July 2 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death. |  |  |   |  |   |
| 22a. SIGNATURE<br>Ramon S. Pimentel  |  | 22b. DATE SIGNED<br>July 2/84  |   | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAMON S. PIMENTEL   |  | 22e. ADDRESS<br>7531 LIBERTY ROAD BALD. 4  |   | 22f. DATE SIGNED   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7/6/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Catholic Men. CR  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cattatus MD.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lock Funeral Home  |  | 24b. ADDRESS<br>1304 N. Central  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 6 1984                                    |   |
| 25b. REGISTRAR'S SIGNATURE<br>W. W. W. W.  |  |  |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEOLA F. CAVEDO  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 29, 1984  |  | 2b. HOUR<br>11:55 AM   |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 30, 1908   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SAINT JOSEPH HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Md.   |  | 13b. CITY OR TOWN<br>Baltimore  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br>508 A Castle Drive 21212   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lawrence M. Derry   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Groves   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |  |
| 16b. SOCIAL SECURITY NO.<br>217-03-2767   |  | 17. INFORMANT<br>William E. Cayedo  |   | ADDRESS<br>508 A Castle Drive<br>Balt., Md. 21212  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>arrhythmia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung abscess</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                         |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                            |  |   |   |  |  |
| 22b. SIGNATURE<br>Walter Koppel   |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>7/30/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Walter Koppel, MD  |  | 22e. ADDRESS  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Aug. 2, 1984  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz, Jr. Funeral Home   |  | ADDRESS<br>3818 Roland Av.<br>Balt., Md. 21211  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 3 1984  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br>John F. ...  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1943 APR 15

BRITISH COLUMBIA

WILSON BRIDGE



BRITISH COLUMBIA

BRITISH COLUMBIA

BRITISH COLUMBIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |  |   | REG. NO. |  |
|---|--|--|--|---|--|---|---|--|---|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Maddie Cephas</i>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>7 / 19 / 84</i>  |   |   | 2b. HOUR<br><i>4:10 PM</i>   |   |          |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 16 1889</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>95</i>  |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><i>YRS</i>   |   |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N. Carolina</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltd. County</i> MD.                    |   |  |   |          |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Stella Maris</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Domestic</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Pvt. Family</i>  |   |          |  |
| 13a. STATE<br><i>Maryland</i>   |  |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><i>2775 W. North Ave. Baltimore, Maryland 21216</i> |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Isaac Carr</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Julia Carr</i>  |  |   |   |  |   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No.</i>  |  |  | 16b. SOCIAL SECURITY NO.<br><i>217-36-2611</i>                         |   | 17. INFORMANT<br><i>Catherine Sifford</i>  |   | 17a. ADDRESS<br><i>2775 W. North Avenue Baltimore, Maryland 21216</i>                           |  |   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Cerebral Vascular Accident</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i>Arteriosclerotic Cardiovascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |   |  |   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a<br><i>Senile Dementia</i>  |  |  |  |   |  |   |   |  |   |          |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 10</i> 19 <i>80</i> to <i>July 19</i> 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>July 9</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |   |          |  |
| 22b. SIGNATURE<br><i>Eddie Nakhwa</i>   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><i>7/19/84</i>   |   |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Eddie Nakhwa</i>  |  |  |  |   | 22e. ADDRESS<br><i>Stella Maris</i>  |   |   |  |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>7/24/1984</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Maryland National Mem.</i>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Laurel, Maryland</i>                           |  |   |          |  |
| 24. FUNERAL HOME<br>NAME<br><i>Nutter &amp; Sons</i>  |  |  | 24b. ADDRESS<br><i>2501 Gwynns Falls Parkway</i>                       |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 24 1984</i>                                 |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |          |  |

BP



|       |             |       |       |       |   |
|-------|-------------|-------|-------|-------|---|
| Isaac | 217-36-2511 | Cathy | Julia | Cathy | 3775 N. North Avenue<br>Baltimore, Maryland 21218 |
| Isaac | 217-36-2511 | Cathy | Julia | Cathy | 3775 N. North Avenue<br>Baltimore, Maryland 21218 |
| Isaac | 217-36-2511 | Cathy | Julia | Cathy | 3775 N. North Avenue<br>Baltimore, Maryland 21218 |
| Isaac | 217-36-2511 | Cathy | Julia | Cathy | 3775 N. North Avenue<br>Baltimore, Maryland 21218 |

7/24/1986  
 2501 Gwynn Falls Parkway  
 Baltimore, Maryland 21218  
 JUL 24 1986  
 2501 Gwynn Falls Parkway  
 Baltimore, Maryland 21218

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN VITAL RECORDS, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| FOR STATE REGISTRAR  |  |                             |  |   |  |                                    |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |     |  |  |  |  | REG. NO. 18029                              |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|-----------------------------|--|---|--|------------------------------------|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|-------------------------|--|--|-----|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES EDWARD MCKINLEY CHAFFMAN, SR.</b><br><i>EDWARD M. Chaffman</i>  |  |                             |  |   |  |                                    |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 28 1984</b><br>MATED <input type="checkbox"/> MONTH DAY YEAR   |  |   |  |  |  |  |  |  |  | 2b. HOUR <b>1:18 PM</b>  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1-27-18</b> |  | 6. AGE IN YEARS<br>YEARS <b>66</b> |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>7 28 1984</b> |  |  |  |  |  |  |  |  |  | 2d. HOUR <b>1:19 PM</b> |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                             |  |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                    |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                |  |  |  |  |  |  |                         |  |  | MD. |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  |                             |  |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |                                    |  |   |  |   |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Carpenter - Union # 101</b> |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>21207</b>  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                             |  |   |  |                                    |  |   |  | 13a. STATE<br><b>Maryland</b>   |  |   |  |  |  |  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  |                         |  |  |     |  |  |  |  | 13c. CITY OR TOWN<br><b>Hayward Heights</b> |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS<br><b>3506 Old Mill Road</b> |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Raymond McKinley Chaffman</b>   |  |                             |  |   |  |                                    |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Albertia Scheckell's</b>   |  |   |  |  |  |  |  |  |  |  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |  |                             |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. II 214-16-8340</b>  |                                    |  |   |  | 17. INFORMANT<br>NAME ADDRESS<br><b>Mrs. Margaret I. Chaffman</b><br><b>3506 Old Mill Rd. Baltimore, Md. 21207</b>  |  |   |  |  |  |  |  |  |  |  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>ASCB</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                             |  |   |  |                                    |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b>                                  |  |  |  |  |  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                             |  |   |  |                                    |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                             |  |   |  |                                    |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                             |  |   |  |                                    |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |   |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                             |  |   |  |                                    |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  |  |  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                             |  |   |  |                                    |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Stanley Z. Feenberg</b>  |  |                             |  |   |  |                                    |  |   |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  |   |  |  |  |  |  |  |  | DATE SIGNED <b>7/28/84</b>   |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>STANLEY Z. FEENBERG MD</b>   |  |                             |  |   |  |                                    |  |   |  | ADDRESS <b>11 E. Chase St 21202</b>   |  |   |  |  |  |  |  |  |  |  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |                             |  |   |  |                                    |  |   |  | 23b. DATE <b>7-31-84</b>  |  |   |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet. Cemetery Garrison Balto. Md.</b> |  |                         |  |  |     |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers Funeral Directors, Inc.</b>  |  |                             |  |   |  |                                    |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 30 1984</b>   |  |   |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Randall</b>                                      |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8728 <sup>E</sup> Liberty Road Randallstown, Maryland 21133  |  |                             |  |   |  |                                    |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |                         |  |  |     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

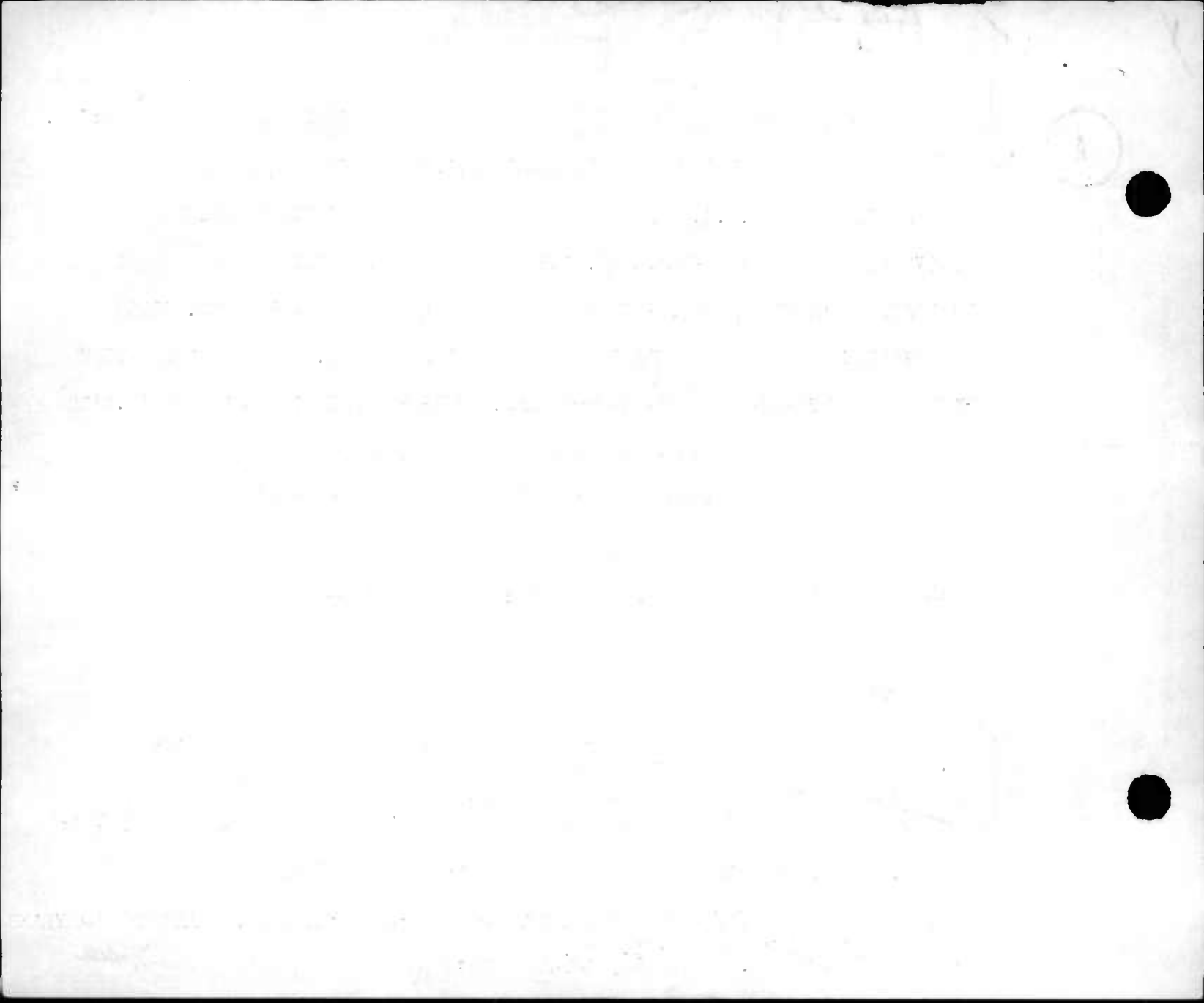
DHMH - 16 50M 4/83  
(VRA 15, 4)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |   |   |  |  |  |
|--|--|---|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DR. NORMAN JEROME CHAPIN  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 1, 1984                 |   |  | 2b. HOUR<br>9:30P. M  |   |  |  |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEBRUARY 11, 1927   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW JERSEY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD                                      |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7 ELM HOLLOW CT. 21208 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DENTIST   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>DENTISTRY  |   |  |  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |   | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>7 ELM HOLLOW CT. 21208   |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM CHAPIN  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RENA M. MOSHKOVICH  |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-28-0157<br>220-20-5996   |   | 17 INFORMANT<br>MRS. PAULINE CHAPIN   |  | ADDRESS<br>7 ELM HOLLOW CT. 21208   |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Well differentiated Lymphoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Bilateral pleural effusions &amp; Ascites</u>   |  |   |   |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>84</u> , to <u>July 1</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>June 5</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                  |  |   |   |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Thomas E. Teufel</u>  |  |   |   |   |  | 22c. DATE SIGNED<br>7/2/84  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. THOMAS TEUFEL   |  |   |   |   |  | 22e. ADDRESS<br>UNIVERSITY HOSPITAL   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>7/3/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW CEM |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>REISTERSTOWN BALTIMORE MARYLAND |  |  |  |
| 24 FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 6 1984   |   |  |  |  |
|  |  |   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                                     |   |  |  |  |

#166 PER CALL WITH  
7/10/84 KAM

84 18030





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18031

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                              |  |  |
|--|--|--|--|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Emma S. Charlton</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 6, 1984</b> |   | 2b. HOUR<br><b>3:15 a.m.</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 28, 1902</b>   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Seamstress</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Reinhart Schulze</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>XXSCHULZ Sophie Herche</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                              | 16b. SOCIAL SECURITY NO.<br><b>215-18-5271</b>   |  |
| 17. INFORMANT<br>ADDRESS<br><b>Mrs. Margaret C Powers 3102 Gibbons Ave</b>   |  | 18. CITY OR TOWN<br><b>21214</b>   |  | 19. STATE<br><b>21214</b>   |                              | 20. ZIP CODE<br><b>21214</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metabolic Acidosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Chronic Renal Failure with Hyperkalemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus and Atherosclerosis</b> |  |  |  |   |                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>Arteriosclerotic Heart Disease, Cerebral Atherosclerosis</b>  |  |  |  |   |                              |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                              | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21g. DATE OF OPERATION  |                              | 21h. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>July 4, 1984</b> , to <b>July 6, 1984</b> , that (we) last saw the deceased alive on <b>July 6, 1984</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.   |  |  |  |   |                              |  |  |
| 22b. SIGNATURE<br><b>M. Vemury M.D.</b>  |  | 22c. DEGREE<br><b>M.D.</b>   |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>             |                              | 22e. DATE SIGNED<br><b>7/6/84</b>  |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. VEMURY M.D.</b>   |  | 22g. ADDRESS<br><b>9000 Franklin Square Drive</b>  |  | 22h. CITY OR TOWN<br><b>Baltimore, Md</b>   |                              | 22i. STATE<br><b>21237</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/9/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc</b>   |  | 24b. ADDRESS<br><b>Baltimore, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 9 1984</b>  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Rendall</b>  |  |

1968

1968

1968

1968

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

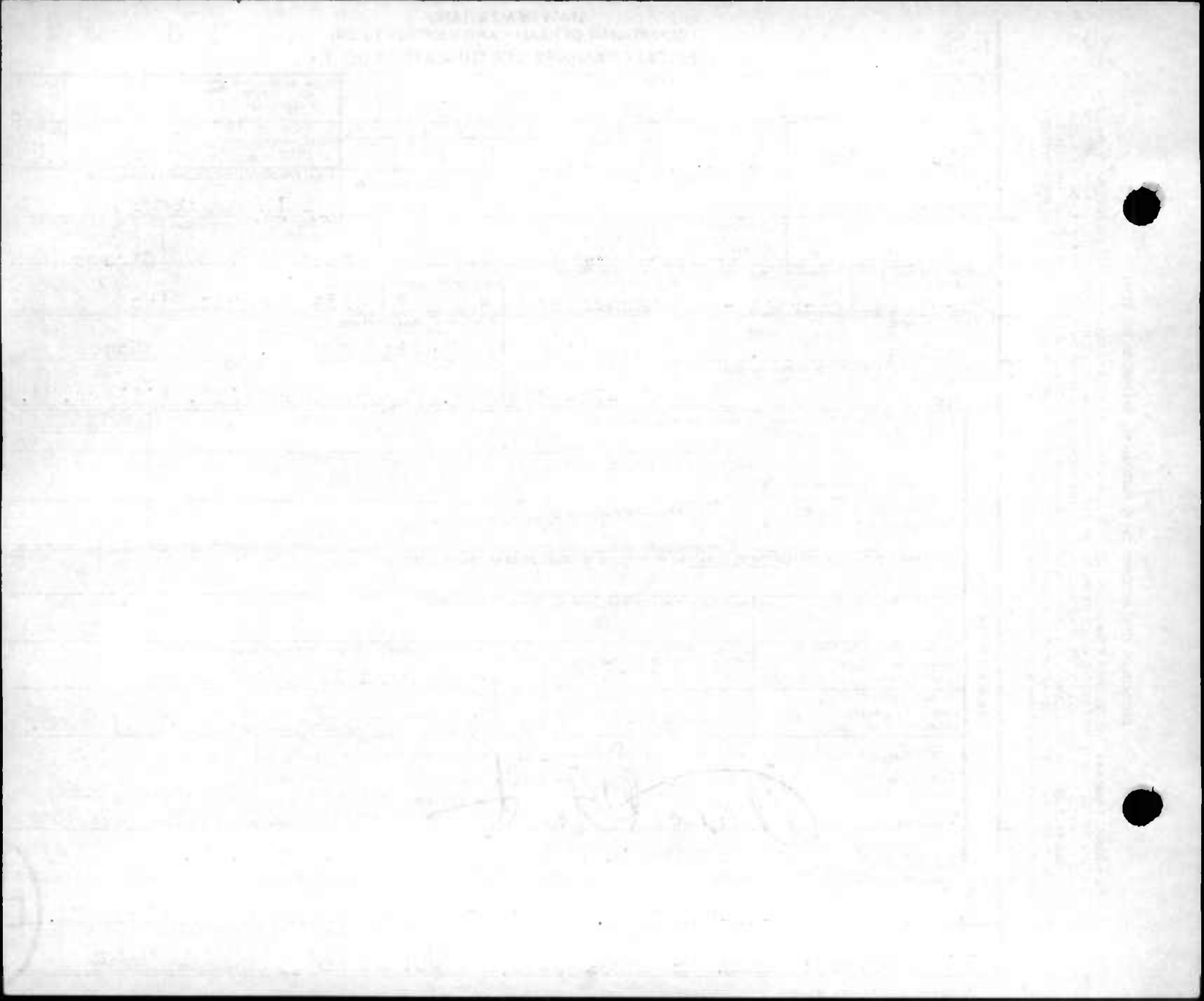
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DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1- STATE REGISTRAR   |  | FOR   |  | 1 8 0 3 2  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  |
| 2. DATE KNOWN OF DEATH   |  | XX MONTH  |  | DAY YEAR   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  |
| Male   |  | White   |  | 2 27 57  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.   |  |
| 2 7 YRS.   |  | MONTHS DAYS   |  | HOURS MIN  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Pennsylvania   |  | USA   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Parkton  |  | Beckleysville Road  |  | Mechanic   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| Maryland   |  | Carroll   |  | Manchester   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16. SOCIAL SECURITY NO.  |  |
| Charles J. Chenowith   |  | Gloria J. Jones   |  | 212-72-5044  |  |
| 17. INFORMANT  |  | ADDRESS   |  | Mr. Joseph Chenowith, Millers, Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Cranio cerebral trauma   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |
| (b)  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |
| (c)  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?   |  |
|  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY HOUR <del>XXXX</del> MONTH DAY YEAR 10:05 AM 7 20 1984                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street                                      |  | 21f. LOCATION CITY OR TOWN COUNTY STATE Beckleysville Rd, Parkton, Balto., Md.   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |  | DATE SIGNED  |  |
| Thomas D. Smith, M.D.  |  | Deputy Chief  |  | 7/21/84  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS   |  | 111 Penn St. Balto., Md.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | 7-23-84   |  | St. Peter's Cemetery Hampstead Balto Md.   |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| Eline Funeral Home, Hampstead, Md.   |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |
|  |  |   |  | JUL 26 1984  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84-18033

1- FOR  
STATE  
REGISTRAR

REG. NO.

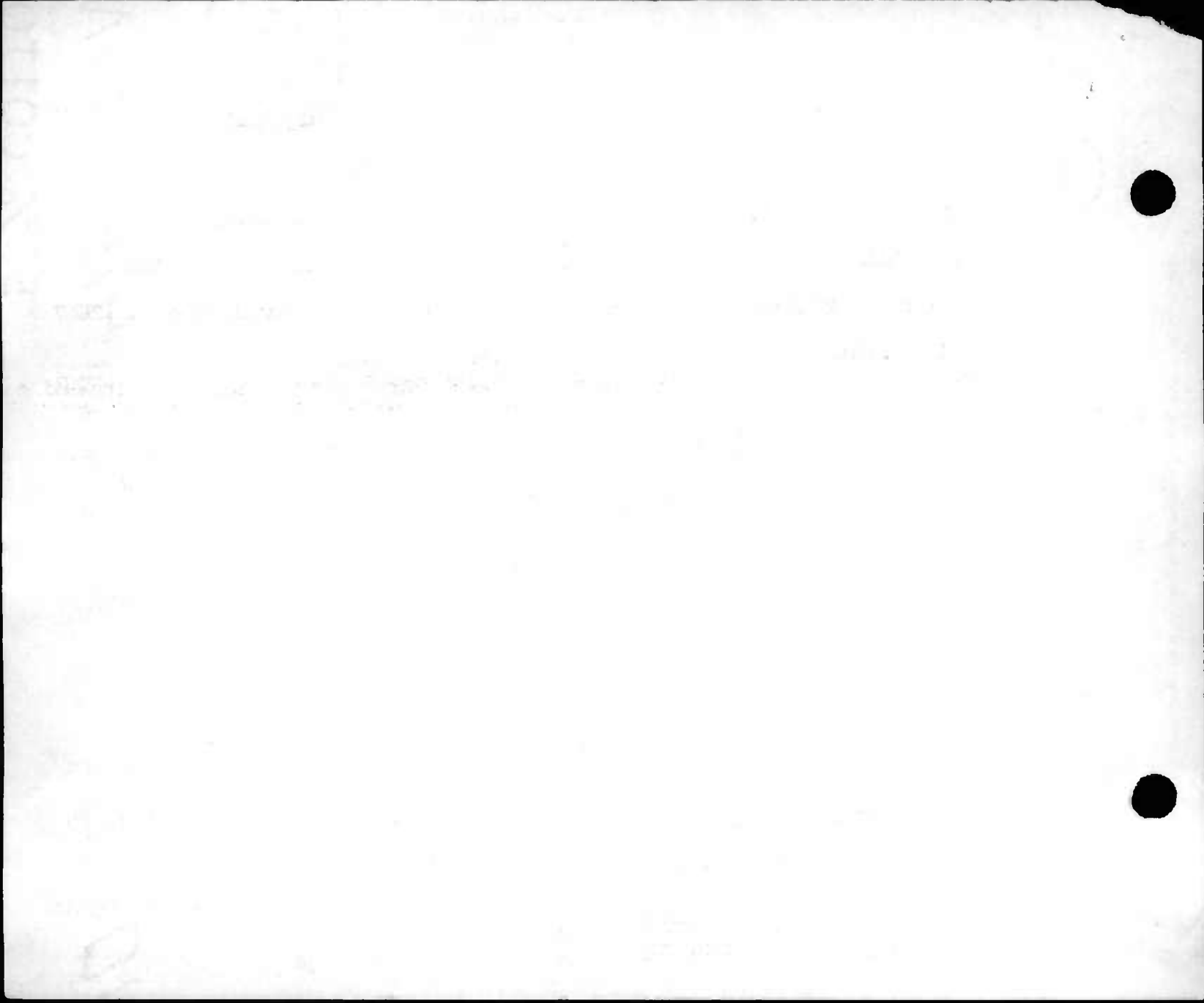
|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. Floyd W. Churn</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 18 1984</b> |   |  | 2b. HOUR<br><b>10 14 AM</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 12 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sears</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3505 Meadowdale Drive 21207</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William E. Churn</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Russell Churn</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-5924</b>  |  | 17. <b>Mrs. Evelyn Churn</b> ADDRESS<br><b>3505 Meadowdale Drive Baltimore, MD. 21207</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cardio respiratory arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days.</b><br><b>4 days</b> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>7/12/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Right carotid artery stenosis</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/6</b> 19 <b>84</b> to <b>7/18</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/18</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Amrithan</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>7/18/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. J. PRADHAN.</b>   |  |   |  | 22e. ADDRESS<br><b>122 SLADE AVE BALTO. M.D.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>07-21-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23d. LOCATION<br><b>Baltimore Maryland</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Loring Evers Funeral Directors, Inc.</b><br><b>8728 Liberty Road Randallstown, Maryland 21133</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Karlson-Randall</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELMER E CLARK</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 7 84</b>  |   | 2b. HOUR<br><b>5<sup>21</sup> PM</b>  |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 14 19</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Machinist</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>   |   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>8525 Oak Rd. 21234</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmer E. Clark</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Kimball</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>218-07-8030</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Marie Dorothy Clark, Same as 13e</b>                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b>                   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b><br><b>3 yrs</b><br><b>yrs</b>                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Co Platt</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>7/3/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Coburn Platt, MD</b>   |   | 22e. ADDRESS<br><b>7620 York Rd Towson Md 21204</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>7-6-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 5 1984</b>  |   |  |
|  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                               |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

CLARK

10-10-30

10-10-30

10-10-30

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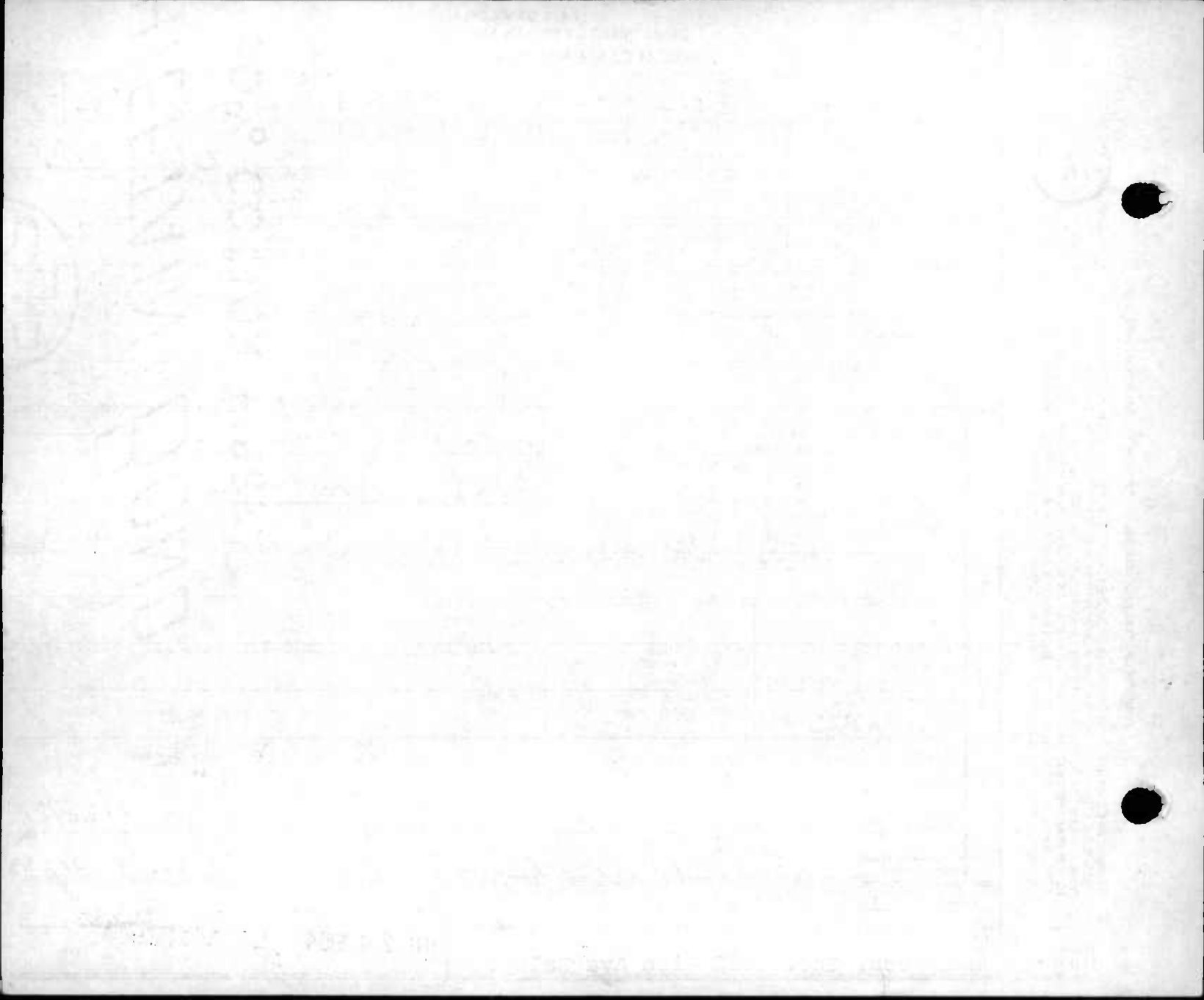
10-10-30

10-10-30



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |   |  |   |  | REG. NO.  |  |  |  |
|---|--|------------------|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                  |  |   |  |   |  |   |  | 4 18035   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARY ELIZABETH CLARK</b>   |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED<br>7-19-84  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>March 24 1917   |  | 6. AGE (IN YEARS)<br>67 YRS   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 2b. DATE PRONOUNCED DEAD<br>7/20/84   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Hampshire  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>118 Briarwood Road 21222 |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Dundalk   |  |                  |  |   |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>118 Briarwood Rd. 21222 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Orin Drak,e  |  |                  |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Not Known   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>002-10-9315D  |  |   |  | 17. INFORMANT ADDRESS<br>Paul H. Clark 3323 Belsford Ct. Balto, MD 21222  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic Aortic Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic cardiocerebral arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.               |  |                  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                  |  |   |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>K.S. Ahluwalia</i>   |  |                  |  | TITLE (SPECIFY)<br>M.D. Deputy  |  |   |  | MEDICAL EXAMINER<br>DATE SIGNED 7/20/84   |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>K.S. AHLUWALIA   |  |                  |  | ADDRESS<br>3112 Dundalk Ave Balto. 21222  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  |                  |  | 23b. DATE<br>7/21/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial                       |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.   |  |                  |  | ADDRESS<br>7922 Wise Ave Balto. MD 21222  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>JUL 24 1984  |  |   |  | 25b. REGISTRAR'S SIGNATURE                     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 4 1 8 0 3 6   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Margaret Elise Clautice</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 25 1984 5<sup>35</sup> P.M.</b>                  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 23 1911</b>                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>72</b>                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson, Md.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, Md.</b>                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Gunther</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth O'Connor</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-74-1526</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Elise Polek, 10711 Lakespring Way, 21030</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>An Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |  |  |  |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1983</b> , to <b>July 25, 1984</b> , that (I) (we) last saw the deceased alive on <b>July 20, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Kendall Faulkner M.D.</b>  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>7/25/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kendall Faulkner M.D.</b>   |  | 22e. ADDRESS<br><b>Stella Maris Hospice</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/28/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto, City Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 27 1984</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>J. E. Lowell Lemmon</b>  |  | ADDRESS<br><b>10 W. Padonia Rd.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |   |  | 84       | 18037 |
|---|--|--|--|---|--|--|--|---|--|----------|-------|
| 1- STATE REGISTRAR ANITA RUSSELL COADY  |  |  |  |   |  |  |  |   |  | REG. NO. |       |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ANITA R. COADY  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>7-9-84 |  |  | 2b. HOUR<br>5 <sup>30</sup> AM  |  |          |       |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 18 94  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |          |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                  |  |   |  |          |       |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Stella Maris Hospice |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |          |       |
| 13a. STATE<br>Md  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Balt'o   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1629 Kirkwood Road 21207  |  |          |       |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph E. Russell  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>Mary Loretta Darraugh  |  |  |  |   |  |          |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>219-10-7624  |  | 17. INFORMANT<br>Edward R. Coady  |  | ADDRESS<br>1629 Kirkwood Road<br>Baltimore, Md. 21207  |  |   |  |          |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CANCER of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC ORGANIC Pulmonary Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |  |  |   |  |  |  |   |  |          |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |  |   |  |          |       |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |          |       |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |          |       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-14</u> 19 <u>82</u> to <u>7-9</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>7-9</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |          |       |
| 22b. SIGNATURE<br><u>EDDIE NAKHODA</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>7-9-84  |  |          |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDDIE NAKHODA  |  |  |  | 22e. ADDRESS<br>STELLA MARIS, Towson, Md  |  |  |  |   |  |          |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>7/11/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |   |  |          |       |
| 24. FUNERAL DIRECTOR NAME<br>Leroy M. & Russell C. Witzke, Funeral Home P.A.<br>1630 Edmondson Avenue, Catonsville, Md. 21228   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 11 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Harrison Randall   |  |          |       |

(A)

5

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 4 1 8 0 3 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |                         |  |  |   |                           |
|---|-------------------------|--|--|---|---------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>PIERCE E. CODY, JR.</b>  |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>07 05 84</b> |   | 2b. HOUR<br><b>1:40AM</b> |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 06 03</b>                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>  |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                            |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON, MD.</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>GBMC-6701 N. CHARLES ST.</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |                           |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MASTER TECH.</b> |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STATE ENG. CO.</b>                                 |  |   |                           |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                  | 13d. STREET ADDRESS / ZIP CODE<br><b>3312 CHASTERTON AVE. 21213</b>   |                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PIERCE E. CODY, SR.</b>                    |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH C. WIGFARTH</b>              |  |   |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>       |                         | 16b. SOCIAL SECURITY NO.<br><b>216 052580</b>  |  | 17. INFORMANT<br><b>FAMILY RECORDS</b>  |                           |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIOPULMONARY ARREST**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**10 MIN.**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

**SQUAMOUS CELL CANCER****4 MONTHS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**S/P MYOCARDIAL INFARCTION**

|  |   |   |   |
|--|---|---|---|
| 19a. DATE OF OPERATION<br><b>4/03/84</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RADICAL NECK DISSECTION FOR<br/>SQ. CELL CA. OF RIGHT NECK</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7/04 1984</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/01 1984</b> to <b>7/05 1984</b> , that (1) <input checked="" type="checkbox"/> I saw the deceased alive or above, (2) <input checked="" type="checkbox"/> I did view the body after death, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated |   |   |   |
| 22b. SIGNATURE<br><b>Dale R. Meyer</b>   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>7/5/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DALE R. MEYER, MD.</b>   |   | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>   |   |

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>JULY 9, 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE PARK</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPL OF MEMORIALS</b> |                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 11 1984</b>           |   |
| ADDRESS<br><b>8800 HARFORD ROAD</b>                             |                                  | REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>           |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified in Baltimore.



8  
1

DATE OF BIRTH: 1907-01-01

DATE OF DEATH: 1963-03-03

THOMAS, GEORGE

CHARLES W. CHAPMAN

DATE OF BIRTH: 1907-01-01

DATE OF DEATH: 1963-03-03

CHAPMAN, GEORGE W.

DATE OF BIRTH: 1907-01-01

DATE OF DEATH: 1963-03-03

DATE OF BIRTH: 1907-01-01

DATE OF BIRTH: 1907-01-01

DATE OF BIRTH: 1907-01-01

1907

1907

1907

1907

DATE OF BIRTH: 1907-01-01



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84

18039

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                            |  |  |
|---|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>NINA B. COLLETT</u>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>7-19-84</u> |   | 2b. HOUR<br><u>8:00 AM</u> |  |  |
| 3. SEX<br><u>F</u>  |  | 4. RACE<br><u>WHITE</u>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>OCT-26-1887</u>  |                            | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><u>96</u><br>YRS MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>W. VA</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTO. CO.</u> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><u>CATONSVILLE</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>1509 IDLEWILDE AVE. 21228</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>HOUSEWIFE</u>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><u>MD.</u>  |  | 13b. COUNTY<br><u>BALTO.</u>  |   | 13c. CITY OR TOWN<br><u>CATONSVILLE</u>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>S. NEWTON BASWORTH</u>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>FLORENCE A. BROWN</u>   |   | 13e. STREET ADDRESS / ZIP CODE<br><u>1509 IDLEWILDE AVE. 21228</u>  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>217-40-2841</u>  |   | 17. INFORMANT<br><u>CAROLYN RESPESS SAME 21228</u>  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arteriosclerosis cardiovascular disease 5 yrs +</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1-2 months</u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |  |   |   |   |                            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) <u>(was)</u> hospital) attended the deceased from <u>1965</u> , 19 <u>July 19</u> , 19 <u>84</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>July 19</u> , 19 <u>84</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> <u>(did not)</u> view the body after death.                          |  |   |   |   |                            |  |  |
| 22b. SIGNATURE<br><u>John A. Nesbitt Jr.</u>  |  |   |   | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                            | 22c. DATE SIGNED<br><u>7-19-84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JOHN A NESBITT JR</u>   |  |   |   | 22e. ADDRESS<br><u>1009 Frederick Pl, Catonsville Md 21228</u>  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>   |  | 23b. DATE<br><u>7-21-84</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Maplewood Cem.</u>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>ELKINS W. VA</u>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>STERLING FH. 736 EDMONDSON AVE.</u>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>JUL 20 1984</u>   |                            | 25b. REGISTRAR'S SIGNATURE<br><u>John A. Nesbitt Jr.</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 4 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Cora Frances Collette   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 1 1984                                   |   | 2b. HOUR<br>M  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 28 1895  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88<br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          | 12b. KIND OF BUSINESS OR INDUSTRY<br>Companion  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |  |   |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Randallstown   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>3903 Noyes Circle 21133                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John T. Brown   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida E. Wisner  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-26-3338  |  | 17. INFORMANT<br>ADDRESS<br>Ms Mary Grace Truitt<br>3903 Noyes Cir.<br>Randallstown, Md 21133 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Myocardial infarction</u><br>(c) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 7)                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 22</u> , 19 <u>84</u> , to <u>June 28</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>June 28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |   |   |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   | 22c. DATE SIGNED<br>7-2-84   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOSE WAGNER, MD  |   | 22e. ADDRESS<br>19 CHARTLEY PARK RD   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>7/5/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Black Rock Baptist Cem.                        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Butler Baltimore Md  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Slack Funeral Home  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 6 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

A

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 12th inst. in relation to the above matter.

I have been instructed to advise you that the same has been forwarded to the proper authorities for their consideration. I am, Sir, very respectfully,  
Yours obedient servant,  
J. H. [Signature]

I am, Sir, very respectfully,  
Yours obedient servant,  
J. H. [Signature]

Corn  
Francis  
Collection  
July 1 1884

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO.   |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Henry M. Comes  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>7-19-84   |  | 2b. HOUR<br>2 AM   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 25 1889   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br>94  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4951 Bucks School House Rd. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employed  |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE (21237)<br>4951 Bucks School House Rd.   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas Comes   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Rohe   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>219-36-0939   |  | 17. INFORMANT ADDRESS<br>Mary Butler 7015 Marietta Ave. 21234   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>A few sclerotic Cardiovascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Left sided CVA</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>8 mos.</i> |  |   |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><i>Extensive Decubitus, also antherosclerotic. Chronic Prostatitis.</i>   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 19 <i>69</i> , to <i>7-19</i> , 19 <i>84</i> , that (I) <del>was</del> last saw the deceased alive on <i>7-18-84</i> , 19 <i>84</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>John C. Hyle</i>   |  |   |  | DEGREE<br><i>M.D.</i><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><i>7-20-84</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John C. Hyle, M.D.   |  |   |  | 22e. ADDRESS<br>Belair Rd. Balto., Md. 21236  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>7-23-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Jos. Ch. Cem.   |  | 23d. LOCATION CITY OR TOWN<br>Baltimore, Maryland  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Lassahn Funeral Home</i>  |  |   |  |   |  | ADDRESS<br><i>7401 Belair Rd.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>8-3-84</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i> |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 4 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. James E.L. Connolly Sr.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 14 1984</b>                                      |  | 2b. HOUR<br>M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 30 1916</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3501 Foxcliffe Court</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chemical Oper.</b>       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Glidden</b>  |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Randallstown</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3501 Foxcliffe Court 21133</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Edward Connolly</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Lydia McCarrier Connolly</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW 2 218-07-2397 A</b>   |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Mrs. Donna Connolly 21133<br/>3501 Foxcliffe Ct. 101 Randallstown Maryland</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer lung -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>C.O.P.D.</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/15</b> 19 <b>84</b> to <b>7/14</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>7/16</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>7/16/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Fellen</b>   |  | 22e. ADDRESS<br><b>P.O. Box 1111, Randallstown, Md 21133</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>07-17-84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>W. Friendship Howard Maryland</b>                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 18 1984</b>   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |  |  |
| 26. ADDRESS<br><b>8728 Liberty Road Randallstown, Maryland 21133</b>   |  |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 4 1 8 0 4 3   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Russell Calvin COOK  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 16, 1984   |  | 2b. HOUR<br>11:02 A   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 5, 1922   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hosp. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dependent  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Parkville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Clifton Cook  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret Baker  |  | 13e. STREET ADDRESS / ZIP CODE<br>3120 Harview Ave. 21234   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>218-34-0073   |  | 17. INFORMANT ADDRESS<br>Dianne S. McClain 3120 Harview Ave. 21234  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 11, 19 84, to July 16, 19 84, that (I) (we) last saw the deceased alive on July 16, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>R. Cardamone MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>7/16/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ralph Cardamone, MD   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Jul 19 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 17 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |
| ADDRESS<br>Baltimore, Maryland   |  |   |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PARKER MESSER COOPER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 24 84 |   |  | 2b. HOUR<br>8:00 A.M.  |   |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 10, 1887   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maine  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Keswick Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self-employed  |   |
|   |  |   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>General Store   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Garrison   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
|   |  |   |  | 13e. STREET ADDRESS / ZIP CODE<br>Olive Lane 21055  |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edwin Cooper  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eliza Messer   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>605-30-4864   |  | 17. INFORMANT<br>Mary E. Nyburg   |  | ADDRESS<br>117 A Cross Keys Rd.<br>Baltimore, MD 21210   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ESOPHAGEAL ACHYLASIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 mins. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Upper Respiratory Infection</u>  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-2-1983</u> to <u>7-24</u> 19 <u>84</u> , that (I) <del>was</del> last saw the deceased <del>on</del> <u>7-24</u> 19 <u>84</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>examined</del> <u>I used the body after death.</u> |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><u>[Signature]</u> DEGREE   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>Jul 24 84</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JOS ZEBBLEY MD</u>  |  |   |  | 22e. ADDRESS  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>07/25/1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, MD  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley, Inc. Dundalk, MD   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 24 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |

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ATTENTION

ATTENTION

Responsible Agent  
ESOMANAL ACHARIS

Upper Respiratory Infection

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JUL 24 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be certified in once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418045

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Elizabeth Alice Core   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>07 09 84                                  |   | 2b. HOUR<br>9:00 AM  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH MONTH DAY YEAR<br>09 13 07   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nsg. Ctr.-Catonsville |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                       |  |
| 13a. STATE<br>Maryland  |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Catonsville  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William J. Hemler  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annie Thomey                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>216-03-2271   |   | 17. INFORMANT ADDRESS<br>1437 Ingleside Avenue<br>Clara Wunder Baltimore, Md. 21228 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of breast - generalized metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/14/83</u> to <u>7/9</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>7/6</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |   |   |   |   |  |
| 22b. SIGNATURE<br><u>John Shaw</u>  |   | DEGREE  |   | 22c. DATE SIGNED<br>7/9/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR JOHN SHAW   |   | 22e. ADDRESS<br>5802 Edmondson Ave Balto Md   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>7/11/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Md.   |
| 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, Md. 21228  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 11 1984                                  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |



20.8 COTTON LBS



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 4 6

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES A. COSTA</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>7</b> YEAR <b>84</b> 2b. HOUR <b>4:20 P.</b> |   |   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>14</b> YEAR <b>54</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>30</b> YRS  |   |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. <b>BALTIMORE CITY OR COUNTY</b> OF DEATH<br><b>BALTIMORE COUNTY</b> MD                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>-</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>  |   | 13b. COUNTY <b>BALTIMORE</b>  | 13c. CITY OR TOWN <b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>7405 GLEN OAK AVE. 21224</b>   |
| 14. FATHER'S NAME<br>FIRST <b>PHILIP</b> MIDDLE <b>J.</b> LAST <b>COSTA, SR.</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>SARAH</b> MIDDLE <b>K.</b> LAST <b>MESSINA</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>215 80 8351</b>  |   | 17. INFORMANT<br><b>FAMILY RECORDS</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>ARDS 2° To influenza complicated E pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Rheumatoid Arthritis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-</b>  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5 - 15</b> , 19 <b>84</b> , to <b>7 - 7</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><b>N. C. Capogrossi</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>7-7-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M.C. CAPOGROSSI</b>   |   | 22e. ADDRESS<br><b>St. JOSEPH HOSPITAL</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>JULY 11, 1984</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDDRESS</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>EVANS CHAPL OF MEMORIES</b> ADDRESS <b>8800 HARFORD ROAD</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 11 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1. STATE  
REGISTRAR

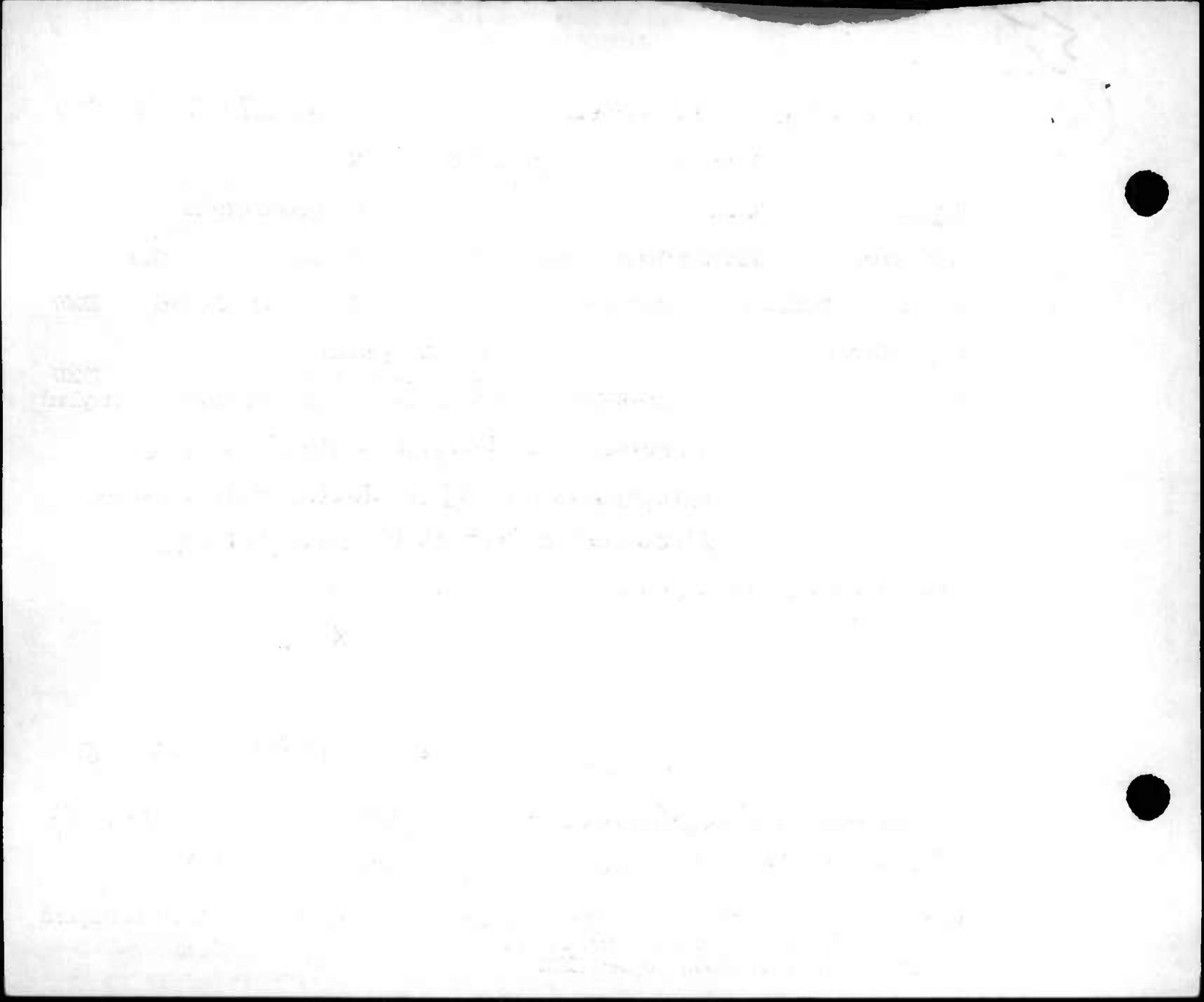
REG. NO.

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|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mrs. Dorothy B. Coufal</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 21 1984</b>   |  |   |  | 2b. HOUR<br><b>12<sup>00</sup> P.M.</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 12 1921</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sears</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6900 Windsor Mill Road 21207</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edley McDonald</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amie J. Sylveus</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>220-07-1149</b>   |  | 17. INFIRMARY ADDRESS<br><b>Mr. Charles Robert Coufal 21207</b><br><b>6900 Windsor Mill Road Baltimore Maryland</b> |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Irreversible Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Malfunctioning of Prosthetic Mitral Valve</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Rheumatic Mitral Valvulopathy</b> |  |   |  |  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0<br><b>Diabetes Mellitus.</b>   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                      |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9-13-</b> 19 <b>65</b> , to <b>7-21-</b> 19 <b>84</b> , that (2) (we) last saw the deceased alive on <b>7-21-</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Cesar Valle Cervero M.D.</b>   |  |   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7-21-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR VALLE CAVERO</b>  |  |   |  |  |  | 22e. ADDRESS<br><b>5310 Old Court Rd</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>7-25-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b><br><b>8728 Liberty Road Randallstown, Maryland 21133</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Rendell</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 4 1 8 0 4 8   |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LAURA G. COWAN</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 10 84</b><br>2b. HOUR<br><b>9:00 PM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 22, 1902</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Randallstown</b>  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas J. Groomes</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><b>Caroline R. Howes</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Margaret Wolf, 22 Millstone Road, 21133</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer (Malignant lymphoma)</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Partial Bowel Obstruction(s)</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>OR NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/10/84</b> , to <b>7/10/84</b> , that (I) (we) lost <b>above</b> , (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>7/10/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. SINBH</b>  |  |   |  | 22e. ADDRESS<br><b>1366H. Bath, MD 21133</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>7/12/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Pk</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Balti Co, Md</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WOODLAWN MEMORIAL FH, 6411 Windsor Mill Road</b>   |  |   |  | 25a. DATE RECD. BY REGISTRAR<br><b>JUL 12 1984</b>  |  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ☒, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMH - 16 50M 4/83  
(VRA 15, 4)

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |                                       |  |
|--|--|--|--|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Frieda Christine CROUSE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 2, 1984</b> |  | 2b. HOUR<br><b>10:20p<sub>M</sub></b> |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 20 22</b>  |                                       |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b>   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Lilly, Penna.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                       |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>  |  | 10. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED Bendix-Franklin Sq</b> |                                       |  |
| 11. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b>   |  | 13. KIND OF BUSINESS OR INDUSTRY   |                                       |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Croll</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Scratchard</b>  |  | 16. STREET ADDRESS / ZIP CODE<br><b>6147 Ebenezer Rd. 21220</b>                                      |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>184-18-2172</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Sharon Myers 6143 Ebenezer Rd. 21220</b>                              |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ |  |  |  |  |                                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |                                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                    |                                       |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                               |                                       |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>July 2</b> 19 <b>84</b> , to <b>July 2</b> 19 <b>84</b> , that (X) (we) last saw the deceased alive on <b>July 2</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>Keith Q. English M.D.</b>   |                                       |  |
| 22c. DATE SIGNED<br><b>7-2-84</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEITH Q. ENGLISH M.D.</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>   |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7-5-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Mem. Gard.</b>                                   |                                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>5-1984</b>   |                                       |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Swinson-Randall</b>   |  | 25c. ADDRESS<br><b>Baltimore, Md. 21201</b>  |  | 25d. DATE REC'D. BY REGISTRAR<br><b>5-1984</b>   |                                       |  |



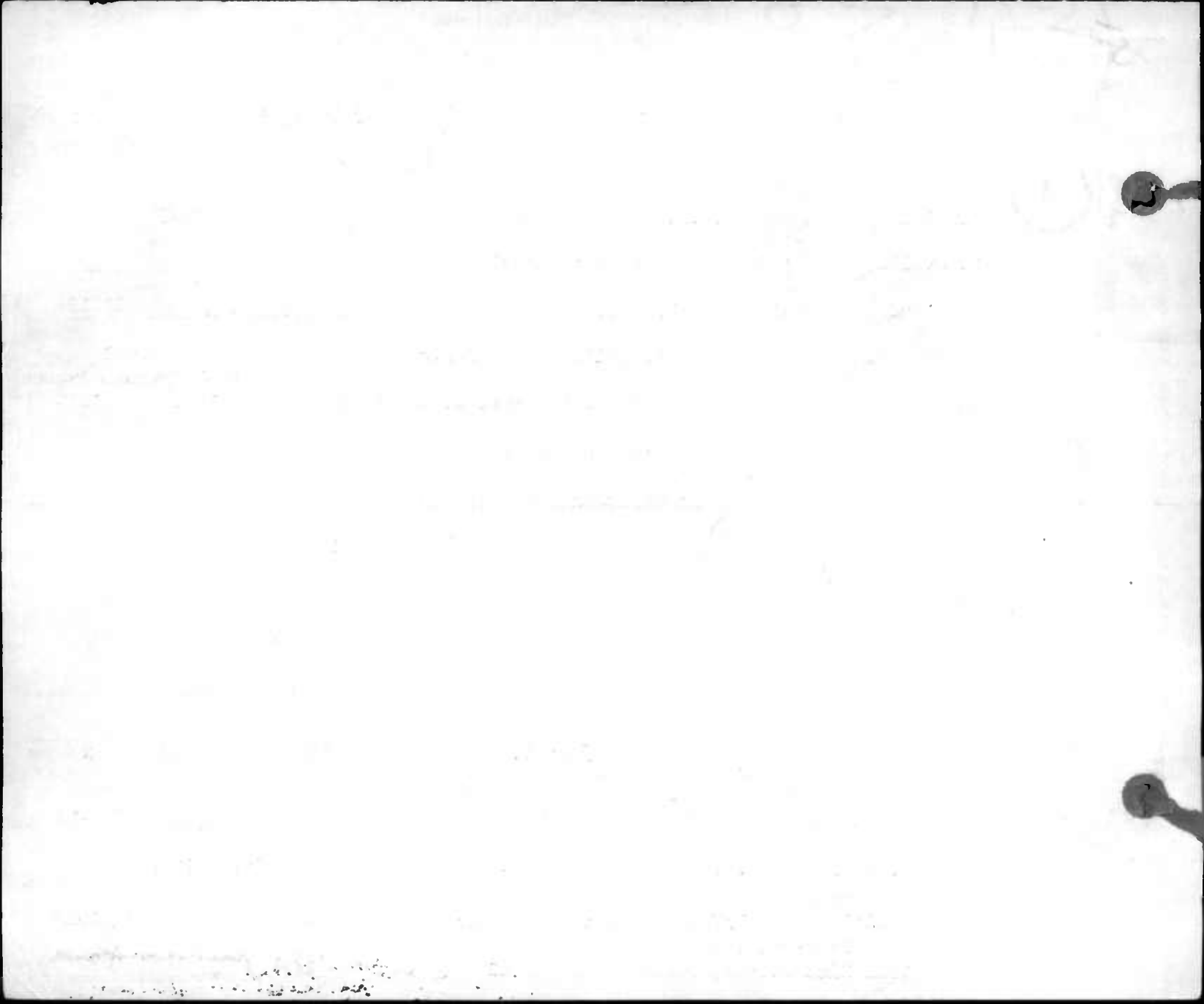
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 5 0

REG. NO.

|  |  |  |  |   |                            |  |
|--|--|--|--|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Esther Lee DAUSES</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 4, 1984</b> |   | 2b. HOUR<br><b>10:45PM</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 4 1885</b>   |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>YRS. MONTHS DAYS<br><b>99</b>                              |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                             |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |                            |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Edgemere</b>  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Houston Franklin</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosie Hoil</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-74-9591</b>   |  | 17. INFORMANT<br><b>Rose B. Isennock</b>  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Cerebrovascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  | 19. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                            |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 11</b> , 19 <b>84</b> , to <b>July 4</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 4</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |                            |  |
| 22b. SIGNATURE<br><i>Delahunt</i> M.D.   |  |  |  | 22c. DATE SIGNED<br><b>7-4-84</b>   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. Delahunt, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/7/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>                                  |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  | 23e. NAME OF CEMETERY OR CREMATORY   |  | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.<br/>7922 Wise Avenue, Dundalk, MD 21222</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 6 1984</b>  |                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John R. Anderson</i>  |  |  |  |   |                            |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the results of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                                     |  |   |  | REG. NO.   |  |
|---|-------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Richard T. Davies Sr.   |                                     |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 22, 1984   |  | 2b. HOUR<br>7:30p. M   |
| 3. SEX<br>M   | 4. RACE<br>W                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2/10/13  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>OHIO   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD. |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE  |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SR. HOSP |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CONSULTANT   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD.   |                                     |  |   | 13b. COUNTY<br>BALTO.  | 13c. CITY OR TOWN<br>ESSEX                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EARL M. DAVIES  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNK   |   | 13e. STREET ADDRESS / ZIP CODE<br>710 S. MARLYN 21221  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNK   |                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213 09 2864   |   | 17. INFORMANT<br>ADDRESS<br>GRACE DAVIES ABOVE   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Sepsis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                     |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                                     |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 19, 1984, to July 22, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 22, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |                                     |  |   |  |  |  |
| 22b. SIGNATURE<br>John M. Vincent, M.D.   |                                     |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>7/22/84  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John M. Vincent, M.D.  |                                     |  |   | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |                                     | 23b. DATE<br>7/26/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MORELANDS  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.G. CONNELLY   |                                     |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 25 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendall   |
| ADDRESS<br>300 MACE   |                                     |  |   |  |  |  |

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WILSON, JAMES

EARL M. DAVIS

EARL M. DAVIS

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 5 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |   |  |  |
|---|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dorothea Beryl Dinker</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>27</b> YEAR <b>1984</b>            |   |  | 2b. HOUR<br><b>3:38</b> M   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>28</b> YEAR <b>1923</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Y.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co., MD.</b>                               |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dulaney Towson Nursing Home</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore City</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3501 St. Paul St. 21218</b>                      |  |
| 14. FATHER'S NAME<br>FIRST <b>Milford</b> MIDDLE <b>H.</b> LAST <b>Dinker, Sr.</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ethel</b> MIDDLE <b>Ike</b> LAST <b></b> |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218 12 7421</b>  |   | 17. INFORMANT ADDRESS<br><b>Mr. T. G. Finkbinder Beltsville, Md.</b>  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line, but may be more than one line)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Carcinoma of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET OF DISEASE AND DEATH <b>6+ Months</b><br><b>1+ yrs.</b> |  |   |   |   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>23 July 1984</b> to <b>27 July 1984</b> , that (I) <del>was</del> lost<br>saw the deceased alive on <b>27 July 1984</b> , and that in my <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above. (I <del>was</del> did not view the body after death.)  |  |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Charles F. O'Donnell</b><br>DEGREE <b>MD</b>   |  |   |   | 22c. DATE SIGNED<br><b>7/28/84</b>  |  |   | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles F. O'Donnell, MD</b>  |  |   |   | 22f. ADDRESS<br><b>7501 York Road 21204</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>7/30/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Md.</b> COUNTY <b></b> STATE <b></b>                |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>MITCHELL-WIEDEFELD HOME, INC.</b> ADDRESS <b>6500 York Rd.</b>  |  |   |   | 25. DATE REC'D. BY REGISTRAR <b>AUG 1 1984</b> REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>   |  |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO : DIRECTOR, FBI  
FROM : SAC, [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

[Large block of illegible text, possibly a memorandum or report body]

Very truly yours,  
[illegible signature]  
[illegible title]  
[illegible text]

Item 16bG595 9/7/84JAB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 5 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HARRY Raymond DE MOSS</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 16, 1984</b> |   | 2b. HOUR<br><b>5:30P</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Dec. 6, 1893</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>90</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dulaney/Towson Nursing Home</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inspector</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Aircraft</b> |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Nelson DeMoss</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Martha Ella Nelson</b>   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-86-4340</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. H.R. DeMoss Jr. 1616 Landon Road 21204</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b> |  |   |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Carotid Artery Atherosclerosis</b>  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>7-9-84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carotid Artery Atherosclerosis</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>Stroke</b>   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)<br><b>Home</b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>1818 Pot Spring Road 21093 Baltimore Md.</b>   |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>July 9, 1984</b> to <b>July 16, 1984</b> , that (I) (we) last saw the deceased alive on <b>7-9-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                            |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Keith A. Manley M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>7-17-84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Keith Manley M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>1818 Pot Spring Road 21093</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-20-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore Md.</b>   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld Home</b>  |  |   |  | ADDRESS<br><b>6500 York Road 21212</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 18 1984</b>  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>  |  |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |   |                                   |
|--|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Leroy J. DeSell</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-6-84</b>  |  | 2b. HOUR<br><b>2:45 P.M.</b>  |                                   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 30 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>  |                                   |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County Baltimore MD</b>                              |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>General Motors Employee</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Lutherville</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Martin H. DeSell</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida L. Bleasing</b>   |  |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>217-07-9680</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Elva Lee DeSell, Same As #13e 21093</b>                      |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Peritonitis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3-4 weeks</b> |   |   |  |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><b>Renal failure, Septic shock, respiratory failure</b>  |   |   |  |   |                                   |
| 19a. DATE OF OPERATION<br><b>5-23-84</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Renal failure, Septic shock, respiratory failure</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |   |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-6-84</b> to <b>7-6-84</b> , that (I) (we) last saw the deceased alive on <b>7-6-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |   |                                   |
| 22b. SIGNATURE<br><b>William H. Macou II MD</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>7-6-84</b>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William H. Macou II MD</b>   |   | 22e. ADDRESS<br><b>7620 York Rd. Towson, Md 21204</b>   |  |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>7-9-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                  |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Balto. Maryland</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>JUL 9 1984</b>  |  |   |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |   | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>   |  | 25. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |                                   |

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1. Mr. J. H. Smith  
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 99. Mr. J. H. Smith  
 100. Mr. J. H. Smith



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 5 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RUBEN A DOBBS</b>                          |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 20 84</b>   |   | 2b. HOUR<br><b>4:10 PM</b>                 |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 30 13</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO/COUNTY</b> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST Joseph's Hos/6700 York RD</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>         |   | 12b. KIND OF BUSINESS OR<br><b>Freight</b> |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>5748 CEDONIA AVE/21206</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Claude Dobbs</b>                     |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma McNamara</b>                           |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-5164</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Margaret Dobbs, same address</b> |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 DAYS</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Septic Hepatic Carcinoma</b>  |  | <b>Years</b>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Gastrointestinal Bleeding</b>  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/23</b> 19 <b>84</b> to <b>7/23</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/23</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>7/23/84</b>   |  |
|  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |
|  |  | 22e. ADDRESS   |  |  |  |

|  |                             |   |  |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b> | 23b. DATE<br><b>7/24/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Crematory</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Schlimmer Funeral Home, Inc.</b>      |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 24 1984</b>               | 25b. REGISTRAR'S SIGNATURE<br><b>W. W. W. W. W.</b>              |
| <b>3331 Brehms Lane, Balto., Md.</b>                             |                             | <b>21213</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

REPORT OF THE

COMMISSIONER OF THE GENERAL LAND OFFICE

TO THE SECRETARY OF THE INTERIOR

FOR THE YEAR 1901

AND FOR THE YEAR 1902

AND FOR THE YEAR 1903

AND FOR THE YEAR 1904

AND FOR THE YEAR 1905

AND FOR THE YEAR 1906

AND FOR THE YEAR 1907

AND FOR THE YEAR 1908

AND FOR THE YEAR 1909

AND FOR THE YEAR 1910

AND FOR THE YEAR 1911

AND FOR THE YEAR 1912

AND FOR THE YEAR 1913

AND FOR THE YEAR 1914

AND FOR THE YEAR 1915

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 5 6

FOR  
1 - STATE  
REGISTRAR

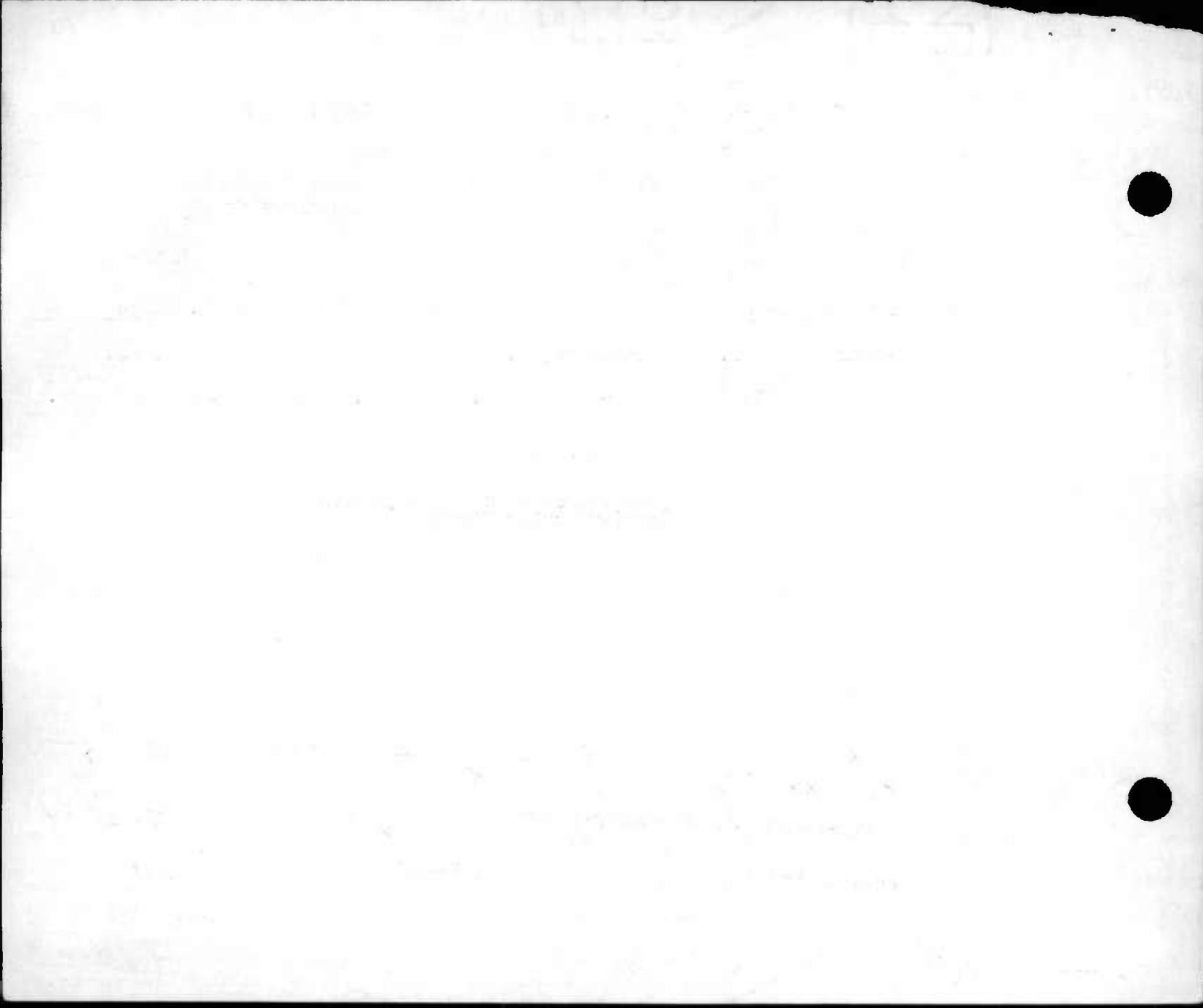
REG. NO.

|   |  |  |  |   |                     |  |
|---|--|--|--|---|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Arthur Thomas Donaldson   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 28, 1984 |   | 2b. HOUR<br>2:25p M |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 20 04   |                     |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY))<br>80   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 8. CITIZEN OF WHAT COUNTRY?<br>USA  |                     |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  | 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |                     |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>STOREKEEPER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SELF-EMPLOYED   |  | 13. STREET ADDRESS / ZIP CODE<br>9127 Belair Rd. 21236  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Arthur T. Donaldson, Sr.  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mae Erhardt   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>WW II   |                     |  |
| 16b. SOCIAL SECURITY NO.<br>820-02-6995   |  | 17. INFORMANT<br>Mrs. Marian E. Donaldson  |  | 18. ADDRESS<br>(21236)<br>9127 Belair Rd.   |                     |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic and Hypertensive Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Asthma</u>   |  |  |  |   |                     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                     |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                     |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (this hospital) attended the deceased from <u>July 22</u> , 19 <u>84</u> , to <u>July 28</u> , 19 <u>84</u> , that (we) last saw the deceased alive on <u>July 28</u> , 19 <u>84</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Norris L. Horwitz</u> MD   |                     |  |
| 22c. DATE SIGNED<br><u>7-28-84</u>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Norris L. Horwitz, M.D.</u>  |  | 22e. ADDRESS<br><u>9000 Franklin Square Drive, 21237</u>  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>7-31-84</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parkwood Cemetery</u>  |                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Maryland</u>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Sassahus FH 7401 Belair Rd</u>  |  | 25. DATE REC'D. BY REGISTRAR<br><u>AUG 01 1984</u>  |                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |                  |   |  |  |  |
|--|------------------|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |                  |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Sister Mary Pius Donegan  |                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 - 23 -84   |  | 2b. HOUR<br>8:15 a.m.  |  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 - 4-1887  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, MD   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Halethorpe  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Residence |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired religious Cath. Sister |  |
| 13a. STATE<br>MD   |                  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Halethorpe  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Owen F. Donegan  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary E. Collins  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |                  | 16b. SOCIAL SECURITY NO.<br>199-40-6157   |  | 17. INFORMANT<br>ADDRESS<br>Sr. Regina Long, 4100 Maple Ave. 21227                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIO SCLEROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>PARKINSON'S</u> |                  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>3 1/2 hrs.</u> |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 19 1984</u> to <u>JULY 1984</u> , that (I) (we) last saw the deceased alive on <u>JUNE 19 1984</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |                  |   |  |  |  |
| 22b. SIGNATURE<br><u>Aidan Walsh</u>   |                  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>7-24-84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Aidan Walsh, M.D.   |                  | 22e. ADDRESS<br>222 St. Paul St., Balto., MD 21202  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>7/26/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral  |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore   |                  | COUNTY<br>MD  |  | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George Gonce   |                  | ADDRESS<br>21225<br>4001 Ritchie Hwy.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 24 1984   |  |
|  |                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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| 1956/57 |  | 1957/58 |  | 1958/59 |  | 1959/60 |  | 1960/61 |  | 1961/62 |  | 1962/63 |  | 1963/64 |  | 1964/65 |  | 1965/66 |  | 1966/67 |  | 1967/68 |  | 1968/69 |  | 1969/70 |  | 1970/71 |  | 1971/72 |  | 1972/73 |  | 1973/74 |  | 1974/75 |  | 1975/76 |  | 1976/77 |  | 1977/78 |  | 1978/79 |  | 1979/80 |  | 1980/81 |  | 1981/82 |  | 1982/83 |  | 1983/84 |  | 1984/85 |  | 1985/86 |  | 1986/87 |  | 1987/88 |  | 1988/89 |  | 1989/90 |  | 1990/91 |  | 1991/92 |  | 1992/93 |  | 1993/94 |  | 1994/95 |  | 1995/96 |  | 1996/97 |  | 1997/98 |  | 1998/99 |  | 1999/00 |  | 2000/01 |  | 2001/02 |  | 2002/03 |  | 2003/04 |  | 2004/05 |  | 2005/06 |  | 2006/07 |  | 2007/08 |  | 2008/09 |  | 2009/10 |  | 2010/11 |  | 2011/12 |  | 2012/13 |  | 2013/14 |  | 2014/15 |  | 2015/16 |  | 2016/17 |  | 2017/18 |  | 2018/19 |  | 2019/20 |  | 2020/21 |  | 2021/22 |  | 2022/23 |  | 2023/24 |  | 2024/25 |  | 2025/26 |  | 2026/27 |  | 2027/28 |  | 2028/29 |  | 2029/30 |  | 2030/31 |  | 2031/32 |  | 2032/33 |  | 2033/34 |  | 2034/35 |  | 2035/36 |  | 2036/37 |  | 2037/38 |  | 2038/39 |  | 2039/40 |  | 2040/41 |  | 2041/42 |  | 2042/43 |  | 2043/44 |  | 2044/45 |  | 2045/46 |  | 2046/47 |  | 2047/48 |  | 2048/49 |  | 2049/50 |  | 2050/51 |  | 2051/52 |  | 2052/53 |  | 2053/54 |  | 2054/55 |  | 2055/56 |  | 2056/57 |  | 2057/58 |  | 2058/59 |  | 2059/60 |  | 2060/61 |  | 2061/62 |  | 2062/63 |  | 2063/64 |  | 2064/65 |  | 2065/66 |  | 2066/67 |  | 2067/68 |  | 2068/69 |  | 2069/70 |  | 2070/71 |  | 2071/72 |  | 2072/73 |  | 2073/74 |  | 2074/75 |  | 2075/76 |  | 2076/77 |  | 2077/78 |  | 2078/79 |  | 2079/80 |  | 2080/81 |  | 2081/82 |  | 2082/83 |  | 2083/84 |  | 2084/85 |  | 2085/86 |  | 2086/87 |  | 2087/88 |  | 2088/89 |  | 2089/90 |  | 2090/91 |  | 2091/92 |  | 2092/93 |  | 2093/94 |  | 2094/95 |  | 2095/96 |  | 2096/97 |  | 2097/98 |  | 2098/99 |  | 2099/00 |  | 2100/01 |  | 2101/02 |  | 2102/03 |  | 2103/04 |  | 2104/05 |  | 2105/06 |  | 2106/07 |  | 2107/08 |  | 2108/09 |  | 2109/10 |  | 2110/11 |  | 2111/12 |  | 2112/13 |  | 2113/14 |  | 2114/15 |  | 2115/16 |  | 2116/17 |  | 2117/18 |  | 2118/19 |  | 2119/20 |  | 2120/21 |  | 2121/22 |  | 2122/23 |  | 2123/24 |  | 2124/25 |  | 2125/26 |  | 2126/27 |  | 2127/28 |  | 2128/29 |  | 2129/30 |  | 2130/31 |  | 2131/32 |  | 2132/33 |  | 2133/34 |  | 2134/35 |  | 2135/36 |  | 2136/37 |  | 2137/38 |  | 2138/39 |  | 2139/40 |  | 2140/41 |  | 2141/42 |  | 2142/43 |  | 2143/44 |  | 2144/45 |  | 2145/46 |  | 2146/47 |  | 2147/48 |  | 2148/49 |  | 2149/50 |  | 2150/51 |  | 2151/52 |  | 2152/53 |  | 2153/54 |  | 2154/55 |  | 2155/56 |  | 2156/57 |  | 2157/58 |  | 2158/59 |  | 2159/60 |  | 2160/61 |  | 2161/62 |  | 2162/63 |  | 2163/64 |  | 2164/65 |  | 2165/66 |  | 2166/67 |  | 2167/68 |  | 2168/69 |  | 2169/70 |  | 2170/71 |  | 2171/72 |  | 2172/73 |  | 2173/74 |  | 2174/75 |  | 2175/76 |  | 2176/77 |  | 2177/78 |  | 2178/79 |  | 2179/80 |  | 2180/81 |  | 2181/82 |  | 2182/83 |  | 2183/84 |  | 2184/85 |  | 2185/86 |  | 2186/87 |  | 2187/88 |  | 2188/89 |  | 2189/90 |  | 2190/91 |  | 2191/92 |  | 2192/93 |  | 2193/94 |  | 2194/95 |  | 2195/96 |  | 2196/97 |  | 2197/98 |  | 2198/99 |  | 2199/00 |  | 2200/01 |  | 2201/02 |  | 2202/03 |  | 2203/04 |  | 2204/05 |  | 2205/06 |  | 2206/07 |  | 2207/08 |  | 2208/09 |  | 2209/10 |  | 2210/11 |  | 2211/12 |  | 2212/13 |  | 2213/14 |  | 2214/15 |  | 2215/16 |  | 2216/17 |  | 2217/18 |  | 2218/19 |  | 2219/20 |  | 2220/21 |  | 2221/22 |  | 2222/23 |  | 2223/24 |  | 2224/25 |  | 2225/26 |  | 2226/27 |  | 2227/28 |  | 2228/29 |  | 2229/30 |  | 2230/31 |  | 2231/32 |  | 2232/33 |  | 2233/34 |  | 2234/35 |  | 2235/36 |  | 2236/37 |  | 2237/38 |  | 2238/39 |  | 2239/40 |  | 2240/41 |  | 2241/42 |  | 2242/43 |  | 2243/44 |  | 2244/45 |  | 2245/46 |  | 2246/47 |  | 2247/48 |  | 2248/49 |  | 2249/50 |  | 2250/51 |  | 2251/52 |  | 2252/53 |  | 2253/54 |  | 2254/55 |  | 2255/56 |  | 2256/57 |  | 2257/58 |  | 2258/59 |  | 2259/60 |  | 2260/61 |  | 2261/62 |  | 2262/63 |  | 2263/64 |  | 2264/65 |  | 2265/66 |  | 2266/67 |  | 2267/68 |  | 2268/69 |  | 2269/70 |  | 2270/71 |  | 2271/72 |  | 2272/73 |  | 2273/74 |  | 2274/75 |  | 2275/76 |  | 2276/77 |  | 2277/78 |  | 2278/79 |  | 2279/80 |  | 2280/81 |  | 2281/82 |  | 2282/83 |  | 2283/84 |  | 2284/85 |  | 2285/86 |  | 2286/87 |  | 2287/88 |  | 2288/89 |  | 2289/90 |  | 2290/91 |  | 2291/92 |  | 2292/93 |  | 2293/94 |  | 2294/95 |  | 2295/96 |  | 2296/97 |  | 2297/98 |  | 2298/99 |  | 2299/00 |  | 2300/01 |  | 2301/02 |  | 2302/03 |  | 2303/04 |  | 2304/05 |  | 2305/06 |  | 2306/07 |  | 2307/08 |  | 2308/09 |  | 2309/10 |  | 2310/11 |  | 2311/12 |  | 2312/13 |  | 2313/14 |  | 2314/15 |  | 2315/16 |  | 2316/17 |  | 2317/18 |  | 2318/19 |  | 2319/20 |  | 2320/21 |  | 2321/22 |  | 2322/23 |  | 2323/24 |  | 2324/25 |  | 2325/26 |  | 2326/27 |  | 2327/28 |  | 2328/29 |  | 2329/30 |  | 2330/31 |  | 2331/32 |  | 2332/33 |  | 2333/34 |  | 2334/35 |  | 2335/36 |  | 2336/37 |  | 2337/38 |  | 2338/39 |  | 2339/40 |  | 2340/41 |  | 2341/42 |  | 2342/43 |  | 2343/44 |  | 2344/45 |  | 2345/46 |  | 2346/47 |  | 2347/48 |  | 2348/49 |  | 2349/50 |  | 2350/51 |  | 2351/52 |  | 2352/53 |  | 2353/54 |  | 2354/55 |  | 2355/56 |  | 2356/57 |  | 2357/58 |  | 2358/59 |  | 2359/60 |  | 2360/61 |  | 2361/62 |  | 2362/63 |  | 2363/64 |  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  |   | REG. NO.   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Norman Robert Dresbach   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 14, 1984   |   |  | 2b. HOUR<br>9 <sup>52</sup> A M  |  |
| 3. SEX<br>M  |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 6, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co., MD.                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6 Burnbrae Road |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Auto  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Towson   |  | 13e. STREET ADDRESS / ZIP CODE<br>6 Burnbrae Road                         |  | 21204  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael J. Dresbach  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth M. Zoll   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Edna F. Dresbach   |  | 6 Burnbrae Rd. - 21204  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic Colon Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>Nov 23, 1983</u> to <u>July 14, 1984</u> , that (1) we last saw the deceased alive on <u>May 24, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.                          |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Charles A. Padgett</u>  |  |  |  |   | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>7/16/84                                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles A. Padgett, MD  |  |  |  |   | 22e. ADDRESS<br>5601 Loch Raven Blvd. Baltimore, Md.   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>7/17/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 18 1984   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Rendell</u>   |  |  |

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# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

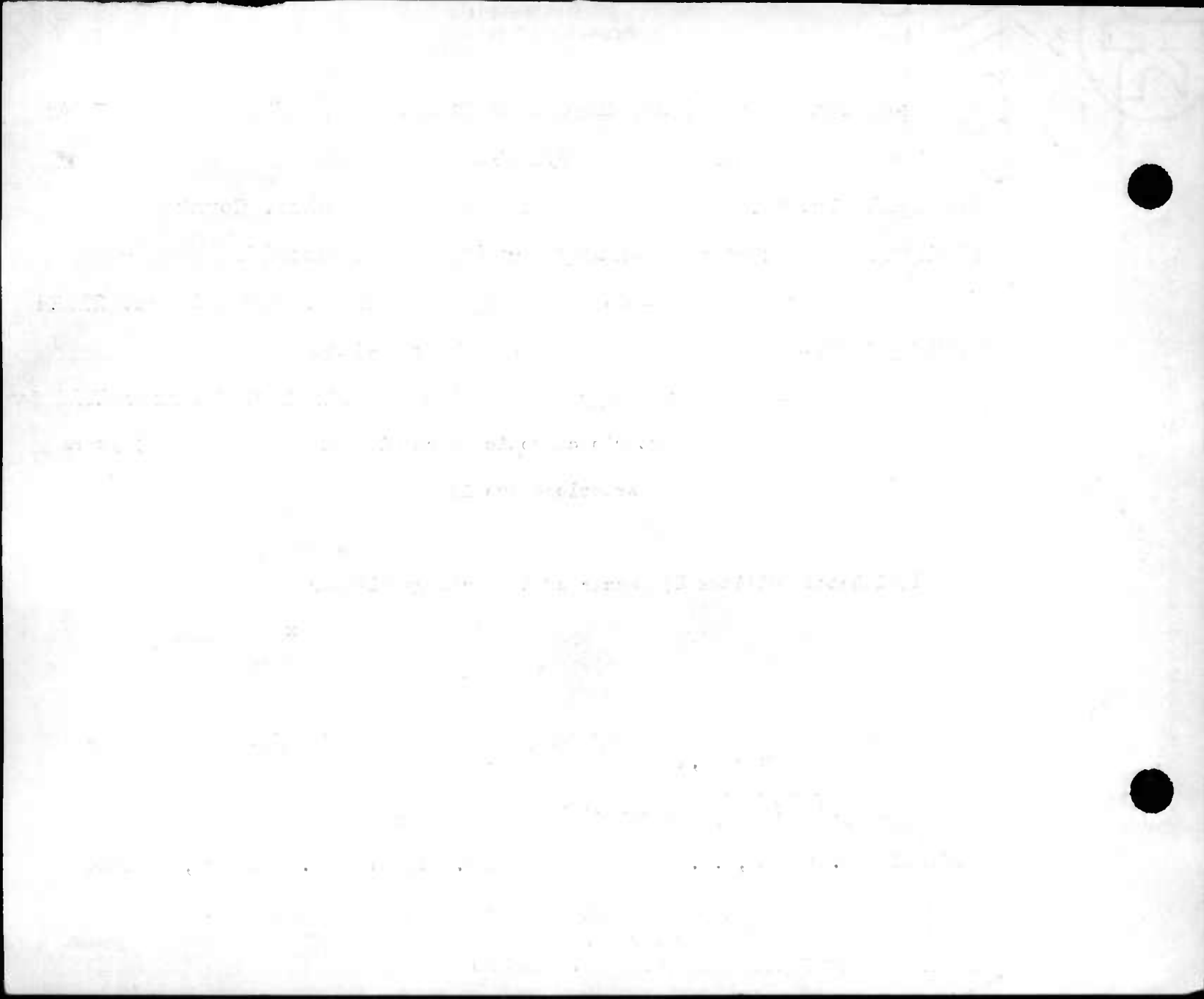
|  |  |  |  |   |  |   |  |  |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  | 2b. HOUR                                     |  |
| Margaret Dukert (AKA) Magdalena Dukat  |  |  |  |   |  |   |  | 7/25/84  |  |  |  | 4:30 AM                                      |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH   |  |   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  |  |  | IF UNDER 1 YEAR                              |  |
| Female   |  | Cauc.  |  | 5/13/92   |  |   |  | 92   |  |  |  | YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |
| Alexandria, Va.  |  | USA  |  |   |  |   |  | Balto. County  |  |  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| Baltimore  |  | Perring Parkway Nursing  |  |   |  | housewife   |  |  |  | -  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE   |  |  |  |  |  |
| Md   |  | -  |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 519 S. Kenwood Ave. 21224  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?                                    |  |  |  |  |  |
| John Przybyl   |  |  |  | Magdalena Kaiser  |  |   |  | 16a. (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                          |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT   |  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))       |  |  |  |  |  |
| 217-54-1317  |  |  |  | Madeline Mengele, 2633 Chesterfield Av  |  |   |  | 21213  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Arteriosclerotic Heart Disease   |  |  |  | Arteriosclerosis  |  |   |  | 5 years  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 1) Diabetes mellitus 2) Cancer of the Urinary Bladder  |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |   |  | 19   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY  |  |   |  | 21f. LOCATION  |  |  |  |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/8/84, 19, to 7/25/84, 19, that (we) last saw the deceased alive on July 25, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |   |  |   |  | DEGREE   |  | 22c. DATE SIGNED   |  |  |  |
| MELITO M. TORRES, M.D.   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |  |   |  | 22e. ADDRESS   |  |  |  |  |  |
|  |  |  |  |   |  |   |  | 441 S. Ellwood Ave. Baltimore, Md 21224  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  | 23d. LOCATION  |  |  |  |
| Burial   |  |  |  | 7/28/84   |  | Holy Rosary Cem.  |  |  |  | Balto., Md.  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |
| Schimunek Funeral Home, Inc.   |  |  |  |   |  |   |  | JUL 30 1984  |  | [Signature]  |  |  |  |
| 3331 Brehms Lane, Balto., Md. 21213  |  |  |  |   |  |   |  |  |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will file a notification of death.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18060

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |       |   |      |   |  |                 |     |                 |                    |  |
|--|---|-------|---|------|---|--|-----------------|-----|-----------------|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)          |   | FIRST | MIDDLE  | LAST | 2a. DATE OF DEATH   |  | MONTH           | DAY | YEAR            | 2b. HOUR           |  |
| PEARL  |   | 9     |   | DULL | 7/11/84   |  |                 |     |                 | 8:2-P <sub>M</sub> |  |
| 3. SEX                                       | 4. RACE   |       | 5. DATE OF BIRTH  |      | 6. AGE (IN YEARS LAST BIRTHDAY)                             |  | IF UNDER 1 YEAR |     | IF UNDER 24 HRS |                    |  |
| Female                                       | white   |       | Feb. 27, 1917   |      | 67  |  | YRS             |     |                 |                    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD |  |                 |     |                 |                    |  |
| Maryland                                     | U.S.A.  |       |   |      |   |  |                 |     |                 |                    |  |
| 10. CITY OR TOWN OF DEATH                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |      | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |                 |     |                 |                    |  |
| TOWSON                                       | GBMC 6701 N CHARLES ST  |       | Ret. State ROADS  |      |   |  |                 |     |                 |                    |  |

|   |             |                   |   |                          |                  |                                |                  |
|---|-------------|-------------------|---|--------------------------|------------------|--------------------------------|------------------|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |             |                   |   | 13d. INSIDE CITY LIMITS? |                  | 13e. STREET ADDRESS / ZIP CODE |                  |
| 13a. STATE  | 13b. COUNTY | 13c. CITY OR TOWN | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          | 8611 Druwood RD. |                                | 21204            |
| Maryland  | Baltimore   | TOWSON            |   |                          |                  |                                | <del>21204</del> |

|                   |        |         |                          |        |      |
|-------------------|--------|---------|--------------------------|--------|------|
| 14. FATHER'S NAME |        |         | 15. MOTHER'S MAIDEN NAME |        |      |
| FIRST             | MIDDLE | LAST    | FIRST                    | MIDDLE | LAST |
| Charles           | Davis  | Gilmore | ROSE                     | Pierce |      |

|  |  |   |  |                  |  |                                  |  |
|--|--|---|--|------------------|--|----------------------------------|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |  | 17. INFORMANT    |  | ADDRESS                          |  |
| No   |  | 220-36-7921   |  | Mrs Anne Emerine |  | 21030 Monroe St. Cookleville Md. |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a)   |  | CARDIO PULMONARY ARREST                         |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.          |  | (b) INFECTION                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
| (c)   |  | PERFORATED BOWEL AND INTRA ABDOMINAL ABSCESES   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|                        |  |  |  |
|------------------------|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>       |

|  |   |   |  |
|--|---|---|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |

|   |  |
|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from 7/11 84 to 7/11 84 that (I) (we) lost<br>saw the deceased alive on 7/11 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |
|---|--|

|  |                      |                             |
|--|----------------------|-----------------------------|
| 22b. SIGNATURE<br>Edward E. Duce MD                      | DEGREE               | 22c. DATE SIGNED<br>7/11/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR EDWARD GRACE | 22e. ADDRESS<br>GBMC |                             |

|  |           |                                    |  |
|--|-----------|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
| Burial                                       | 7/14/84   | Moreland Memorial Pk.              | Baltimore, Maryland                        |

|  |                               |                            |
|--|-------------------------------|----------------------------|
| 24. FUNERAL DIRECTOR<br>NAME             | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Leonard J. Ruck Inc. Baltimore, Maryland | JUL 16 1984                   | John Davidson-Randall      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

(2)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418061

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |                               |  |
|--|--|---|---|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE ELIZABETH LAST DUNKERLY   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7/7/84 July 7 1984 |  | 2b. HOUR<br>5P.M.             |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 4 1886                                       |                               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>97 YRS  |                               |  |
| 10. CITY OR TOWN OF DEATH<br>Woodlawn  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2611 Larchmont Dr. 21207 |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |                               |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home             |  |                               |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Baltimore                                  |  | 13c. CITY OR TOWN<br>Woodlawn |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO<br>212-18-9592  |   | 17. INFORMANT<br>Joseph Andrews  |                               |  |
|  |  |   |   | ADDRESS<br>2611 Larchmont Dr. 21207  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Senility</u> |  |   |   |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):<br><u>Perforation duodenal ulcer colon</u>  |  |   |   |  |                               |  |
| 19a. DATE OF OPERATION<br><u>April 1984</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>perforation + abscess</u>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR AM. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                               |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>April 1984</u> to <u>July 7 1984</u> , that (I) (we) last saw the deceased alive on <u>July 7 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  |   |   |  |                               |  |
| 22b. SIGNATURE<br><u>A. Bradley Daugharethy MD</u>   |  |   |   | 22c. DATE SIGNED<br><u>7-7-84</u>  |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. Bradley Daugharethy  |  |   |   | 22e. ADDRESS<br>1264 Francis Ave. Arbutus 21227                                      |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7/10/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery                         |                               |  |
|  |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                          |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>1630 Edmondson Ave. Catonsville, Md.<br>LeRoy M. & Russell C. Witzke Funeral Home  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 9 1984  |                               |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Russell</u>                          |                               |  |

MEDICAL CERTIFICATION



7/17/84 rja

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>VERNON DUNLAP   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07 - 22 - 84                            |   | 2b. HOUR<br>8:10 PM  |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 21, 1903   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH'S HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor | 12b. KIND OF BUSINESS OR INDUSTRY<br>Telephone  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>21234   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Dunlap   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Lang   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>212-03-6946   | 17. INFORMANT<br>ADDRESS<br>21234<br>Nellie R. Dunlap 8811 Littlewood Rd.      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ATHEROSCLEROTIC CORONARY DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>Prostate Cancer</u>   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> , 19 <u>84</u> , to <u>7/22</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>7/22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Edward Wolf</u>   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>7/22/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Edward Wolf   |  | 22e. ADDRESS<br>6408 Elray Drive, Balt., MD   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>July 26, '84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., MD                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson   |  | ADDRESS<br>8521 Loch Raven Blvd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 23 1984  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rodell</u>                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418063

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA KATHERINE DUPUY   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7/21/84  |   | 2b. HOUR<br>5:00P M   |   |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec 16, 1904  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79<br>YRS MONTHS DAYS HOURS MIN.                             |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC 6701 N CHARLES ST |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ACCOUNTYANT |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Aircraft |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Towson   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Ritter   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sophia Mueller   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>214-01-3085   |   | 17. INFORMANT<br>ADDRESS<br>Mr. Lud Dupuy 604 Piccadilly Road 21204                             |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) BREAST CANCER WITH METASTASIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>SEPSIS   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/21 1984 to 7/21 1984, that (I) (we) last saw the deceased alive on 7/21 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |   |
| 22b. SIGNATURE<br>Gerald H. Hillman   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>7/21/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR T.H. HILLMAN  |   | 22e. ADDRESS<br>GBMC  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>7-25-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Pk. Baltimore Md.                       |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 24 1984  |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home   |   | ADDRESS<br>6500 York Road 21212   |   | 25b. REGISTRAR'S SIGNATURE<br>Lina Davidson-Randall   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

and:

YTHWISN/NOV17.2.2

THEY ARE NOT THE SAME

114750

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 6 4

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |                            |   |  |   |  |   |  |
|--|--|--|--|--|----------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN J DURHAM</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-8-84</b> |  | 2b. HOUR<br><b>9:14 PM</b> |   |  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 09 1920</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>YRS.</b>            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                    |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |  |  |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Crown Cork Sea</b>  |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>516 Savage Street 21224</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bernard Durham</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anne Fischer</b>   |                            |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-09-7667</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Clara Durham- 516 Savage Street 21224</b>  |                            |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>MASSIVE RIGHT PULMONARY THROMBOEMBOLISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1-2 HRS.</b>                                     |  |  |  |  |                            |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MIN.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CARDIAC HYPERTROPHY</b>   |  |  |  |  |                            |   |  |   |  |   |  |
| 9a. DATE OF OPERATION  |  | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |                            | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7-8 1984</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                            |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>DEPT OF PATH. ST. JOSEPH HOSP, BALTO. MD.</b>  |                            |   |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7-8</b> 19 <b>84</b> , to <b>7-8</b> 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7-8</b> 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                            |   |  |   |  | 22c. DATE SIGNED<br><b>7/9/84</b>                           |  |
| 22b. SIGNATURE<br><b>JAMES W. EAGAN, JR., M.D.</b>   |  |  |  | DEGREE<br><b>MD.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                            |   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES W. EAGAN, JR., M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>DEPT OF PATH. ST. JOSEPH HOSP, BALTO. MD.</b>   |                            |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>07/12/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus</b>   |                            |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Walter Dabrowski - 1005 Dundalk Avenue 21224</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 10 1984</b>  |                            |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>na Davidson-Randall</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed in this 72 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                     |   |   |  |   |   |  |   | REG. NO. 18065  |  |
|---|--|-------------------------------------|---|---|--|---|---|--|---|---|--|
| 1- STATE REGISTRAR  |  |                                     |   |   |  |   |   |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) Carmo Frances Earl  |  |                                     |   |   |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED  |  | 2b. HOUR                                  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White                    |   | 5. DATE OF BIRTH<br>Aug. 30 1917                            |  | 6. AGE<br>66  |   | 7. DATE<br>Pronounced Dead                               |   | 7b. HOUR  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |   | 8. MARRIED<br>WIDOWED                                       |  | 8. NEVER MARRIED<br>DIVORCED  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County |   | 9. MD   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237  |  |                                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Sq. Hospital |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                                     |   |   |  |   |   |  |   |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore            |   | 13c. CITY OR TOWN<br>Essex 21221                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>1003 N. Marlyn Ave. 21221         |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Drayer  |  |                                     |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Helldorfer                           |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                                     |   | 16b. SOCIAL SECURITY NO.<br>217 80 2078                     |  | 17. INFORMANT<br>William Earl, Husband  |   |  | 17. ADDRESS<br>Same                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                                     |   |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                                     |   |   |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |                                     |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                                     |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                                     |   |   |  |   |   |  |   |   |  |
| ACTUAL SIGNATURE<br><u>Charles O'Donnell</u>  |  |                                     |   | TITLE (SPECIFY)<br>Deputy                                   |  |   |   | DATE SIGNED<br>7/11/84                                   |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Charles O'Donnell, M.D.   |  |                                     |   | ADDRESS<br>7501 York Rd. Balto., Md. 21204                  |  |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  |                                     |   | 23b. DATE<br>2/14/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Memorial Gardens                               |   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.                    |  |
| 24. FUNERAL HOME<br>Brazdzinski Funeral Home PA 1407  |  |                                     |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 16 1984                |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>         |   |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN TO THE DIVISION OF VITAL RECORDS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |  |  |   |  |   |  | REG. NO.  |  |  |  |
|---|--|------------------|--|--|--|---|--|---|--|---|--|--|--|
| 1- REGISTRAR  |  |                  |  |  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Thomas Eck  |  |                  |  |  |  |   |  |   |  | 2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR<br>7 16 19 84                      |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Cauc. |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4/10/52   |  | 6. AGE (IN YEARS) (LAST BIRTHDAY)<br>32 YRS.  |  | IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>7 16 19 84                               |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Belair & Miller Roads |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sheet Metal Worker   |  | 12b. KIND OF BUSINESS<br>Ingleside Construction                                     |  |  |  |
| 13a. STATE<br>Md.   |  |                  |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13e. STREET ADDRESS<br>9505 Oakbranch Way 21236   |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Edmund Eck   |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Frances McCabe  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>215-60-0568  |  | 17. INFORMANT ADDRESS<br>Diane Eck, same address  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8120 IMMEDIATE CAUSE (a) Multiple injuries<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR MONTH DAY YEAR<br>6:04 P.M. 7 16 19 84  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Driver in multiple vehicle collision |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br>Belair & Miller Rds. Balto., MD.   |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.   |  |                  |  | TITLE (SPECIFY)<br>Deputy Chief  |  |   |  | DATE SIGNED<br>7/17/84  |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |                  |  | ADDRESS<br>111 Penn St. Balto., MD.  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>7/20/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., Md.                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>Schmunek Funeral Home, Inc.<br>9705 Belair Road, Balto., Md. 21236  |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 18 1984  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall |  |

11-15-50



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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8418067

FOR  
 1- STATE  
 REGISTRAR

REG. NO.

|  |  |   |  |   |                                      |   |  |  |  |  |  |
|--|--|---|--|---|--------------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CATHERINE MARIE ELLIS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 1, 1984</b> |   | 2b. HOUR<br><b>7:30a<sub>m</sub></b> |   |  |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 10, 1901</b>  |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>YRS.</b> |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, County MD</b>                             |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dulaney Towson Nursing Center</b> |  |   |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State of Md.</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>123 W. 29th St. 21218</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Francis Sauer</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Miller</b>  |                                      |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-2218</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Gloria Jean Evans, 1316 Walker Ave. 21239</b>  |                                      |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____    |  |   |  |   |                                      |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |                                      |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                      |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1900 E. Northern Pkwy. Dundalk Balto. Md.</b>   |                                      |   |  |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>6/12/84</b> 19 <b>8.3</b> , to <b>7/2</b> 19 <b>84</b> , that (1) (we) lost now the deceased alive on <b>6/12/84</b> 19 <b>8.3</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (and) (not) view the body after death. |  |   |  |   |                                      |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Meredith Smith</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |                                      |   |  | 22c. DATE SIGNED<br><b>July 2, 1984</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Meredith Smith, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>1900 E. Northern Pkwy.</b>   |                                      |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>July 5, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk Balto. Md.</b>                         |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b><br><b>6009 Harford Rd., Balto., Md. 21214</b>  |  |   |  |   |                                      | 25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1984</b>   |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |   |                                      |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 sheet any injury, or other traumatic event, the medical examiner must be notified.

1

WINTER

WINTER

WINTER

JUL 2 1952

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 18-22a 7/26/84 mtb F#593

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |         |   |                  |  |   |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
|---|--|---------|---|------------------|--|---|--|----------------|-----------------------------------|------------------|--|--|--|------------------|--|---------|--|-------------------|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         | FIRST MIDDLE LAST   |                  |  | 2a. DATE KNOWN OF DEATH   |  |                | MONTH DAY YEAR                    |                  |  | 7b. HOUR                                     |  |                  |  |         |  |                   |  |                     |  |
| JAMES   |  |         | ELSBERY   |                  |  | 7c. DATE PRONOUNCED DEAD  |  |                | 7d. MONTH DAY YEAR                |                  |  | 7e. HOUR                                     |  |                  |  |         |  |                   |  |                     |  |
| 3. SEX  |  | 4. RACE |   | 5. DATE OF BIRTH |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR. |                                   | IF UNDER 24 HRS. |  | 7f. DATE PRONOUNCED DEAD                     |  | 7g. HOUR         |  |         |  |                   |  |                     |  |
| M   |  | W       |   | 2 01 1948        |  | 36 YRS.   |  | MONTHS DAYS    |                                   | HOURS MIN.       |  | 7 2 1984                                     |  | 4:15 PM          |  |         |  |                   |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |                  |  | 8. MARRIED  |  |                | NEVER MARRIED                     |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |                  |  |         |  |                   |  |                     |  |
| OKLAHOMA  |  |         | U.S.A.  |                  |  | WIDOWED   |  |                | DIVORCED                          |                  |  | Baltimore County MD.                         |  |                  |  |         |  |                   |  |                     |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |                | 12b. KIND OF BUSINESS OR INDUSTRY |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| Towson  |  |         | (motel) 1507 E. Joppa Rd.                                   |                  |  | THERAPIST   |  |                | RADIATION                         |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| 13a. STATE  |  |         | 13b. COUNTY   |                  |  | 13c. CITY OR TOWN   |  |                | 13d. INSIDE CITY LIMITS?          |                  |  | 13e. STREET ADDRESS                          |  |                  |  |         |  |                   |  |                     |  |
| MD.   |  |         | BALTO.  |                  |  | BALTO.  |  |                | YES NO                            |                  |  | 5 DUNHAVER PL. 21236                         |  |                  |  |         |  |                   |  |                     |  |
| 14. FATHER'S NAME   |  |         | 15. MOTHER'S MAIDEN NAME                                    |                  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |                | 16b. SOCIAL SECURITY NO.          |                  |  | 17. INFORMANT ADDRESS                        |  |                  |  |         |  |                   |  |                     |  |
| ROBERT VAUGHN ELSBERRY  |  |         | EMILY M. BLECHER  |                  |  | NO  |  |                | 212-54-6277                       |                  |  | RITA ELSBERRY 5 DUNHAVER AL.                 |  |                  |  |         |  |                   |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |   |                  |  |   |  |                |                                   |                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                  |  |         |  |                   |  |                     |  |
| PART I DEATH WAS CAUSED BY:   |  |         |   |                  |  |   |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| IMMEDIATE CAUSE (a) Amitriptyline intoxication  |  |         |   |                  |  |   |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |   |                  |  |   |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |         |   |                  |  |   |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| (b)   |  |         |   |                  |  |   |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |   |                  |  |   |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| (c)   |  |         |   |                  |  |   |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d). |  |         |   |                  |  |   |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| 19a. DATE OF OPERATION  |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                  |  |   |  |                |                                   |                  |  | 20. AUTOPSY?                                 |  |                  |  |         |  |                   |  |                     |  |
|   |  |         |   |                  |  |   |  |                |                                   |                  |  | YES NO                                       |  |                  |  |         |  |                   |  |                     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  |         | 21b. TIME OF INJURY   |                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
|   |  |         | P.M. 7/2 19 81  |                  |  | subject ingested drug.  |  |                |                                   |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK  |  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                  |  | 21f. LOCATION   |  |                | CITY OR TOWN                      |                  |  | COUNTY STATE                                 |  |                  |  |         |  |                   |  |                     |  |
|   |  |         | Motel   |                  |  | 1507 E. Joppa Rd.   |  |                | Towson, Md.                       |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |         |   |                  |  |   |  |                |                                   |                  |  | Autopsy                                      |  | Inspection       |  | Inquiry |  | and in my opinion |  |                     |  |
| death resulted from:  |  |         |   |                  |  |   |  |                |                                   |                  |  | Natural causes                               |  | Accident         |  | Suicide |  | Homicide          |  | Undetermined manner |  |
| ACTUAL SIGNATURE  |  |         |   |                  |  |   |  |                |                                   |                  |  | TITLE (SPECIFY)                              |  | DATE SIGNED      |  |         |  |                   |  |                     |  |
| Ann M. Dixon, M.D.  |  |         |   |                  |  |   |  |                |                                   |                  |  | M.D. Assistant                               |  | MEDICAL EXAMINER |  | 7-3-84  |  |                   |  |                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |   |                  |  |   |  |                |                                   |                  |  | ADDRESS                                      |  |                  |  |         |  |                   |  |                     |  |
| Ann M. Dixon, M.D.  |  |         |   |                  |  |   |  |                |                                   |                  |  | 111 Penn St., Balto., Md.                    |  | 21201            |  |         |  |                   |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         | 23b. DATE   |                  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                | 23d. LOCATION                     |                  |  | COUNTY STATE                                 |  |                  |  |         |  |                   |  |                     |  |
| BURIAL  |  |         | 7/6/84  |                  |  | GARDENS OF FAITH  |  |                | BALTO.                            |                  |  | MD.  |  |                  |  |         |  |                   |  |                     |  |
| 24. FUNERAL DIRECTOR NAME   |  |         | ADDRESS   |                  |  | 25a. DATE REC'D. BY REGISTRAR   |  |                | 25b. REGISTRAR'S SIGNATURE        |                  |  |  |  |                  |  |         |  |                   |  |                     |  |
| CONNELLY A.H.   |  |         | 300 MACC AVE. Z1  |                  |  | JUL 11 1984   |  |                | J. H. Davidson                    |                  |  |  |  |                  |  |         |  |                   |  |                     |  |

WIND

CRAB

11/10/1941  
JUL 1 1941

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18069

1- FOR  
STATE  
REGISTRAR

REG. NO.

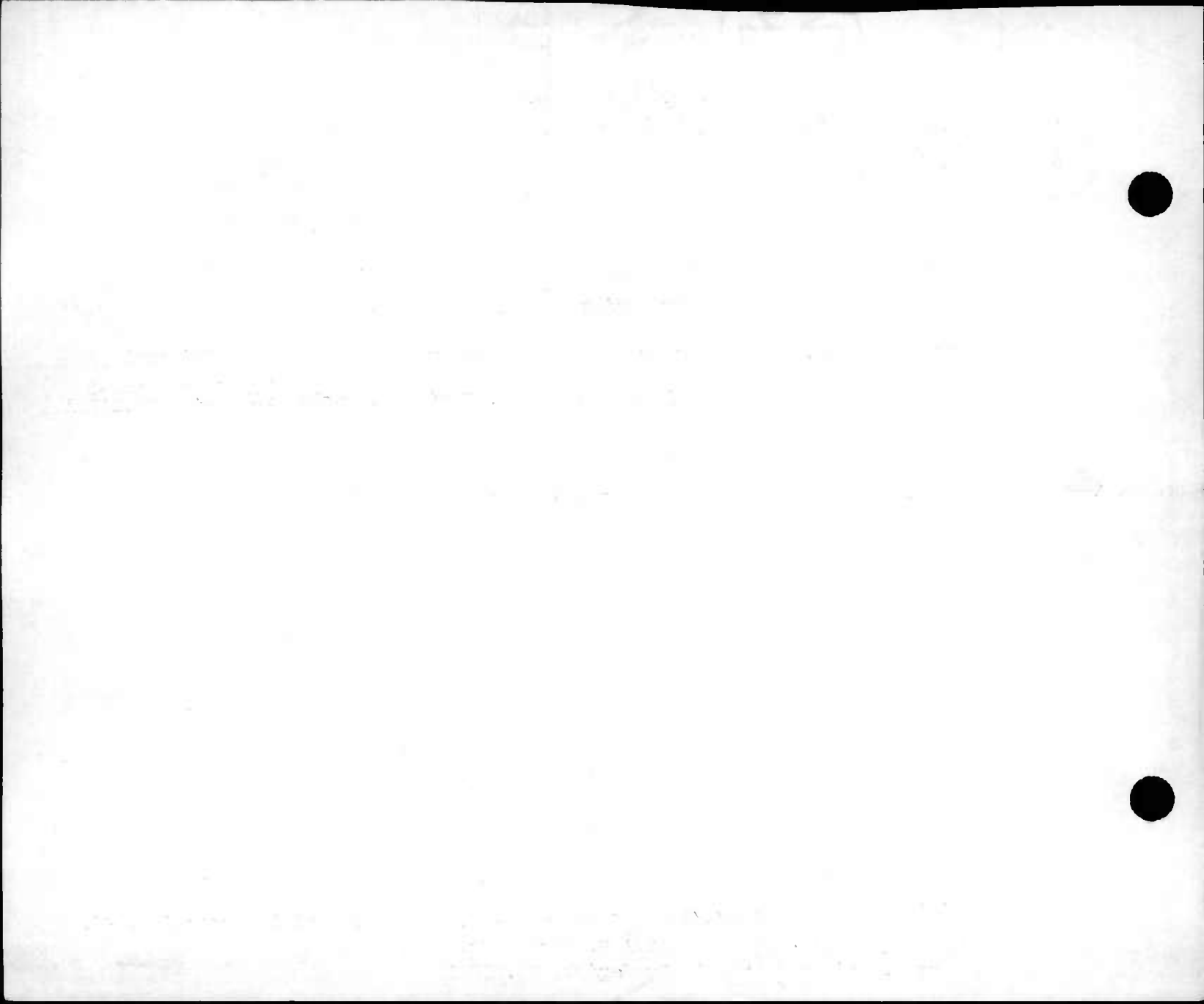
|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>PEARL ESTHER ENGLE</b><br><i>Pearl Engle</i>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 2 1984</b>  |  | 2b. HOUR<br><b>10:35 PM</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 02 1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76 YRS</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore General</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SPRINGFIELD</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Frederick</b>  |  | 13c. CITY OR TOWN<br><b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George W. Gosser</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Esther Heimbach</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>387 PEARL ST 21701</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>171-05-2086</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr. Isaiah H. Engle 387 Pearl Street Frederick, Md. 21701</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Exsanguination</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>G.I. BLEED AND D.I.C.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)          |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>2 9</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 2</b> , 19 <b>84</b> , to <b>JULY 2</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>JULY 2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Allan J. Church M.D.</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>7-2-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allan J. Church M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>32-K-Stock Mill Rd 21208</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>Jul/6/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resthaven Mem. Gar.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Darley &amp; Son, PA</b>  |  | ADDRESS<br><b>1201 N. Market St Frederick, Md. 21701</b>   |  | 25. DATE RECEIVED BY REGISTRAR<br><b>JUL 11 1984</b>  |  | 25a. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8418070

FOR  
 1- STATE  
 REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE CATHARINE LAST ENOS                           |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 31, 1984  |  | 2b. HOUR<br>8:45A M  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 30, 1898  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD. |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dulaney Towson Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                |  |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Timonium   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>206 Quaker Ridge Rd. 21093 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Eugene Evans   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susanna Price  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |  | 16b. SOCIAL SECURITY NO.<br>215-05-8498D  |   | 17. INFORMANT<br>ADDRESS<br>Robert E. Enos - Same as #13e    |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
 gave rise to immediate  
 cause (a), stating the  
 underlying cause last

(b) Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c) Aortic stenosis

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

Diabetes mellitus, atrial fib

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Feb. 6</u> , 19 <u>61</u> , to <u>July 31</u> , 19 <u>84</u> , that (I) (we) last<br>saw the deceased alive on <u>July 20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><i>Donald O. Wood</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>7/31/84   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donald O. Wood, M.D.   |  | 22e. ADDRESS<br>2 Greenweadow Drive  |   |

|   |                     |   |  |
|---|---------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                        | 23b. DATE<br>8-3-84 | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. 1050 York Road |                     | 25. DATE REC'D. BY REGISTRAR<br>AUG 2 1984        | 25b. REGISTRAR'S SIGNATURE<br><i>Donald O. Wood</i>              |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNA W. ESTES</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE - 7 - 9 - 84</b>                    |   | 2b. HOUR<br><b>12:40 AM</b>  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 - 14 - 08</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>                    |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Towson</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel T. Wiltbank</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hester Register</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>219-28-5022</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Frederic D. Rstes 20 Lake Lorraine Circle Shalima, Fla.</b>      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 mins</b><br><b>4 days</b> |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/7/84</b> 19 <b>7/9/84</b> 19 <b>7/10/84</b> that (I) (we) last saw the deceased alive on <b>7/8/84</b> 19 <b>7/9/84</b> and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>John D. Messina M.D.</b>  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>7/10/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John D. Messina M.D.</b>   |   | 22e. ADDRESS<br><b>7401 Osler Dr. Towson, Md 21204</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><b>Burial</b>  |   | 23b. DATE<br><b>July 11, 1984</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chester Cemetery</b>                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Chestertown, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 11 1984</b>   |  |   |  |

BP

Leonard J. Luck, Inc. Baltimore, Md.

July 11, 1984 Chester Cemetery

Chester, Maryland

Serial

No 919-28-7029 Frederick D. Bates  
Shiloh, Pa.  
50 Lake Lorraine Circle  
Chester, Pa.  
T. Wilbank  
Hector  
1079 Northern Parkway 21270  
Chester  
Dept. Store  
U.S.A.  
x

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P-7

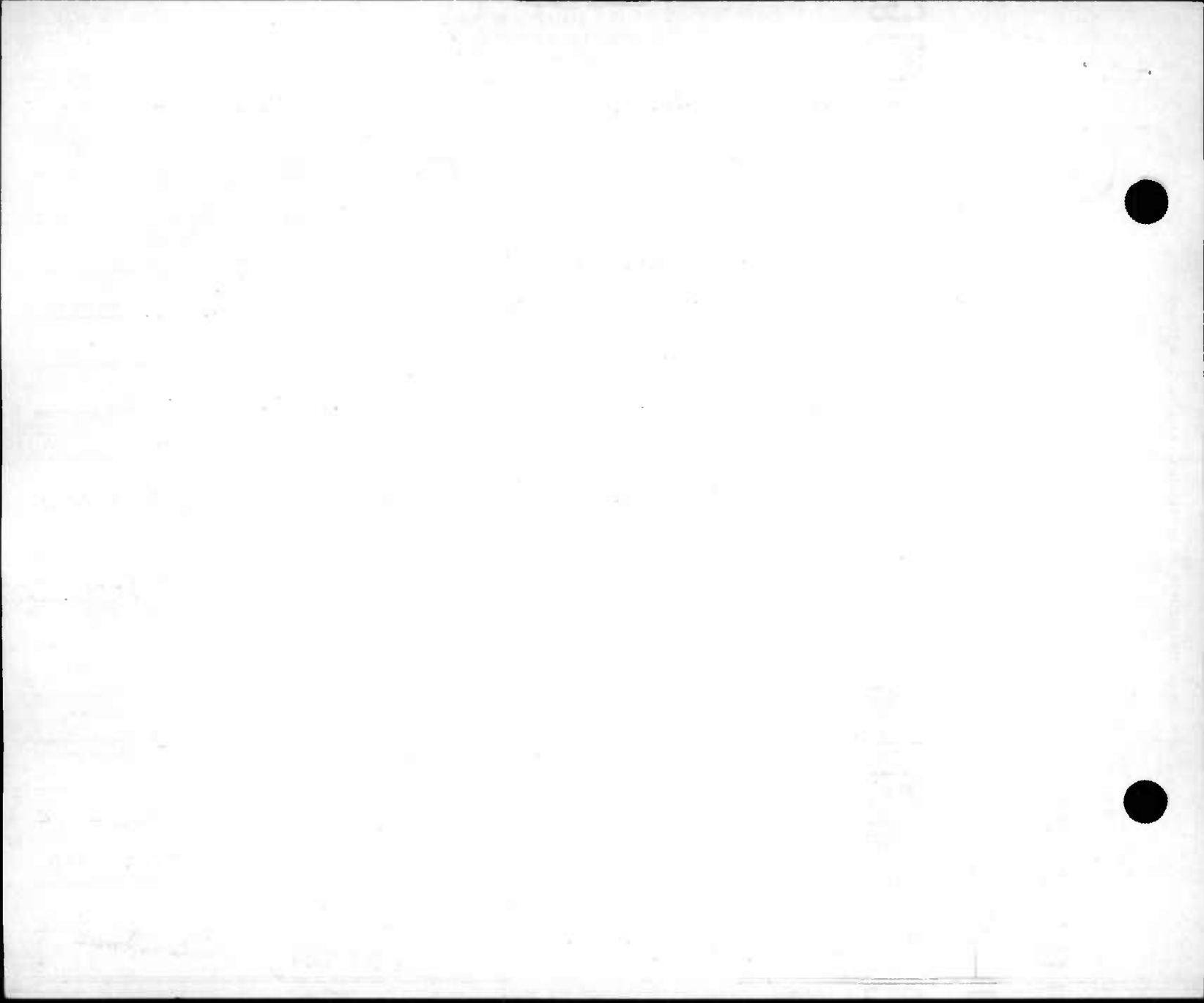
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 7 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ZYAMA FABRIKANT   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7-23-84  |  | 2b. HOUR<br>10:15 P.M.   |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-1-1895   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br>GARRISON  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GARRISON VALLEY NURSING HOME |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MERCHANT                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL                                    |  |
| 13a. STATE<br>MARYLAND   | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS APT. 102<br>5715 PARK HTS. AVE. 21215                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MOISHE FABRICANT   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>592-01-6069  | 17. INFORMANT<br>SOPHIE VAVULITSKY<br>4613 HORIZON CIR., APT. 203 #21208                        |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>ventricular Arrhythmia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>IMMEDIATE</u><br><u>IMMEDIATE</u> |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Chronic Renal Insufficiency, Anemia, S.P. Tracheostomy</u>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-23-1984</u> to <u>7-23-1984</u> , that (I) (we) last saw the deceased alive on <u>7-23-1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><u>S. Khan</u>   |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>7-24-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SHAUKAT Y. KHAN   |   | 22e. ADDRESS<br>1528 KING WILLIAM DRIVE, BALTO, MD.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  | 23b. DATE<br>7/24/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND               |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 26 1984  |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

34 18073

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Julia E. FABULA  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 26, 1984  |   | 2b. HOUR<br>6:00 <sup>a</sup> M                                 |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 22 1902  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD   |   |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |   |   |
| 13a. STATE<br>MD   | 13b. COUNTY<br>BALTO  | 13c. CITY OR TOWN<br>BALTO  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1806 BANK ST. 21224   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN --- MICKEL  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JULIE --- ---  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>214123473   |   | 17. INFORMANT<br>ADDRESS<br>21237<br>Josephine Kozlowski 1614 Elligson Rd   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Diabetes Mellitus, Arteriosclerotic Cardiovascular Disease, Atrial Fibrillation<br>Poor Mental Status.  |   |   |   |   |   |
| 19. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 17, 19 84, to JULY 26, 19 84, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on JULY 26, 19 84, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (do) (do not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br>Darius Russin MD   |   |   | 22c. DATE SIGNED<br>JULY 26, 1984   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DARIUS RUSSIN, M.D.    |
| 22e. ADDRESS<br>9000 FRANKLIN SQUARE DR., 21237  |   |   | 22f. DATE REC'D. BY REGISTRAR<br>JUL 27 1984  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>7/30/84  | 23c. NAME OF CEMETERY OR CREMATOR<br>St. Stanislaus   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto Balto MD    |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jeffrey  |   |   | 25. REGISTRAR'S SIGNATURE<br>John Davidson  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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ALWAYS USE IT!

EJF-Vol. 97

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• 38 YEARS OLD

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18074

1- FOR  
STATE  
REGISTRAR

REG. NO.

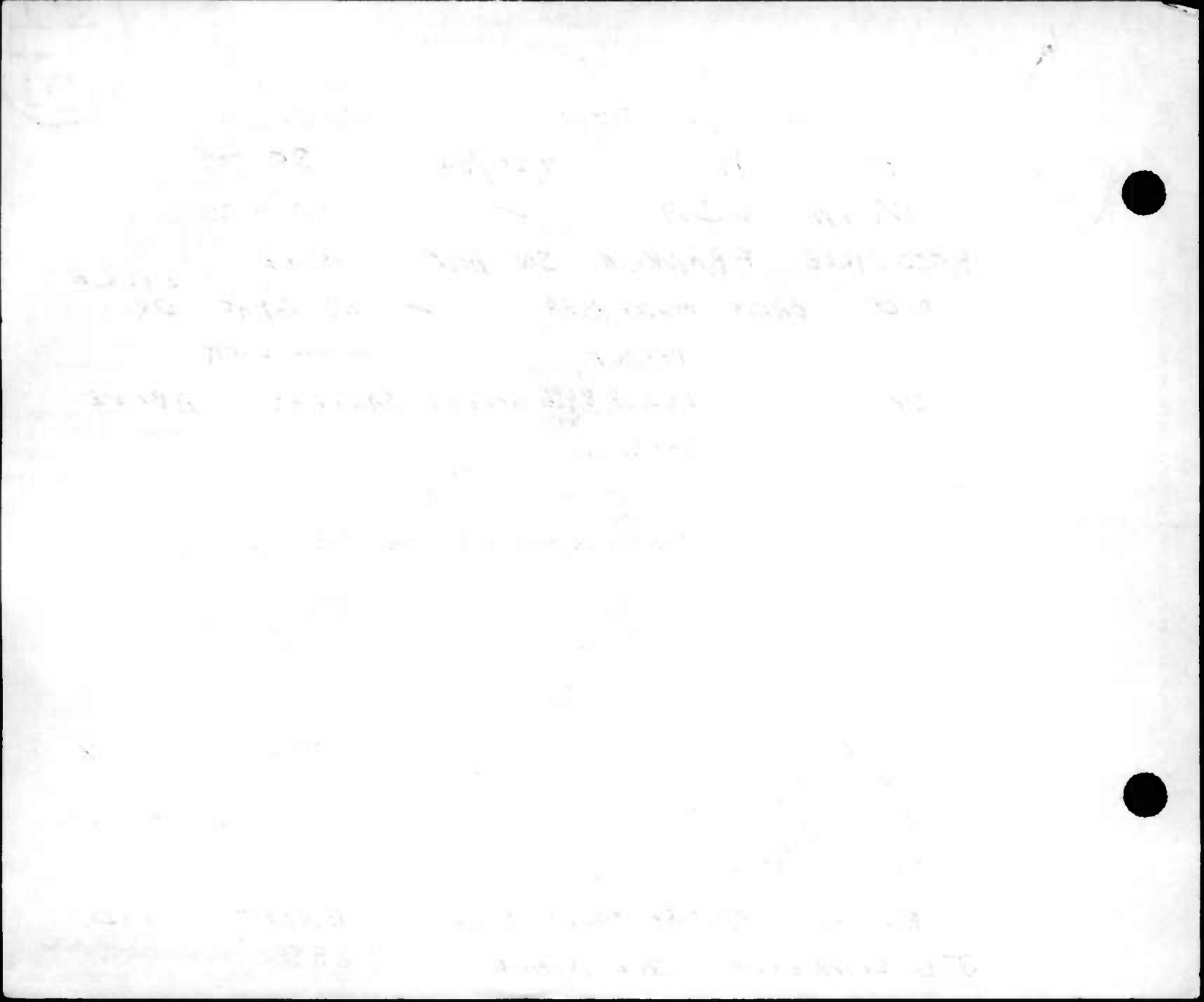
|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Grace V. Farmer   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 22, 1984  |  | 2b. HOUR<br>3:35pm   |
| 3. SEX<br>F   | 4. RACE<br>W  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7/20/04                          |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. VA.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ. HOSP. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HSWE  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MO.   | 13b. COUNTY<br>BALTO  | 13c. CITY OR TOWN<br>MIDDLE RIVER                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS / ZIP CODE<br>27 GYAO DR. 21220                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>PERDUE  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNK                   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>232 88 8486 |   | 17. INFORMANT<br>ADDRESS<br>ROBERT SANDERS ABOVE                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Insulin Dependent Diabetes Mellitus</u> |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 22, 19 84, to July 22, 19 84, that <input checked="" type="checkbox"/> (we) lost above <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (we) (did not) lose the body after death.  |   |  |   |  |  |
| 22b. SIGNATURE<br>Keith English MD  |   | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>7/22/84  |  |
| 22d. PHYSICIAN'S NAME<br>KEITH ENGLISH, M.D.  |   | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237                      |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |   | 23b. DATE<br>7/25/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLLY HILL  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.G. CONNELLY   |   | ADDRESS<br>300 MACE  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 25 1984   |  |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |   |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lydia</b> <b>E.</b> <b>Ferris</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>07</b> DAY <b>18</b> YEAR <b>84</b>  |  | 2b. HOUR <b>6:45</b> MIN <b>A</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>11</b> YEAR <b>90</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Nsg. Ctr-Catonsville</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |   |  |
| 13a. STATE <b>20814</b> COUNTY <b>Montgomery</b>   |  | 13b. CITY OR TOWN <b>Bethesda</b>  |  | 13c. STREET ADDRESS / ZIP CODE<br><b>9403 Fresno Road 20814</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>August</b> MIDDLE LAST <b>Johnson</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Alice</b> MIDDLE LAST <b>Lindgran</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>559-01-5709</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Joan E. Ramage item 13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNE - Unknown</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pre-eclampsia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>P.V.D.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 20</b> , 19 <b>83</b> , to <b>7-18-84</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>7-17-84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>George Auger</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED<br><b>7-18-84</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE AUGER</b>   |  | 22e. ADDRESS<br><b>3750 Wilkins Dr Baltimore</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>7/19/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland MD.</b>  |  | 24. FUNERAL DIRECTOR<br><b>Jos. Gawler's Sons, Inc.</b><br><b>5136 Misc. Av. NW Wash. DC 20016</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 23 1984</b>   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18076

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |  |  |
|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RAYMOND C. FINK</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7. 16. 84</b>                                     |  |  | 2b. HOUR<br><b>1:15A.M.</b>  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Cauc.</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 - 17 - 1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Gen. Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Funeral Director</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mortuary</b> |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Randallstown</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bernard A. Fink</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen B. Crump</b>  |   | 16. STREET ADDRESS / ZIP CODE<br><b>3626 Temple Rd 21133</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-8578</b>  |   | 17. INFORMANT<br><b>Clara G. Fink</b>  |  | ADDRESS<br><b>3626 Temple Rd.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lymphoma. Diabetes mellitus.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.     |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-22-84</b> , 19 <b>84</b> , to <b>7. 16</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7. 16</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Govinda Rao</b>  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7. 16. 84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYMOND GOVINDA RAO</b>   |  | 22e. ADDRESS<br><b>Balt County Genl Hospital</b>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-18-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore - Md</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Fink Funeral Home</b>  |  | ADDRESS<br><b>Glen Burnie, Md</b>   |   | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 17 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

*[Faint, illegible handwritten notes on lined paper]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 ! 8 0 7 7

FOR  
1 - STATE  
REGISTRAR

REG. NO.

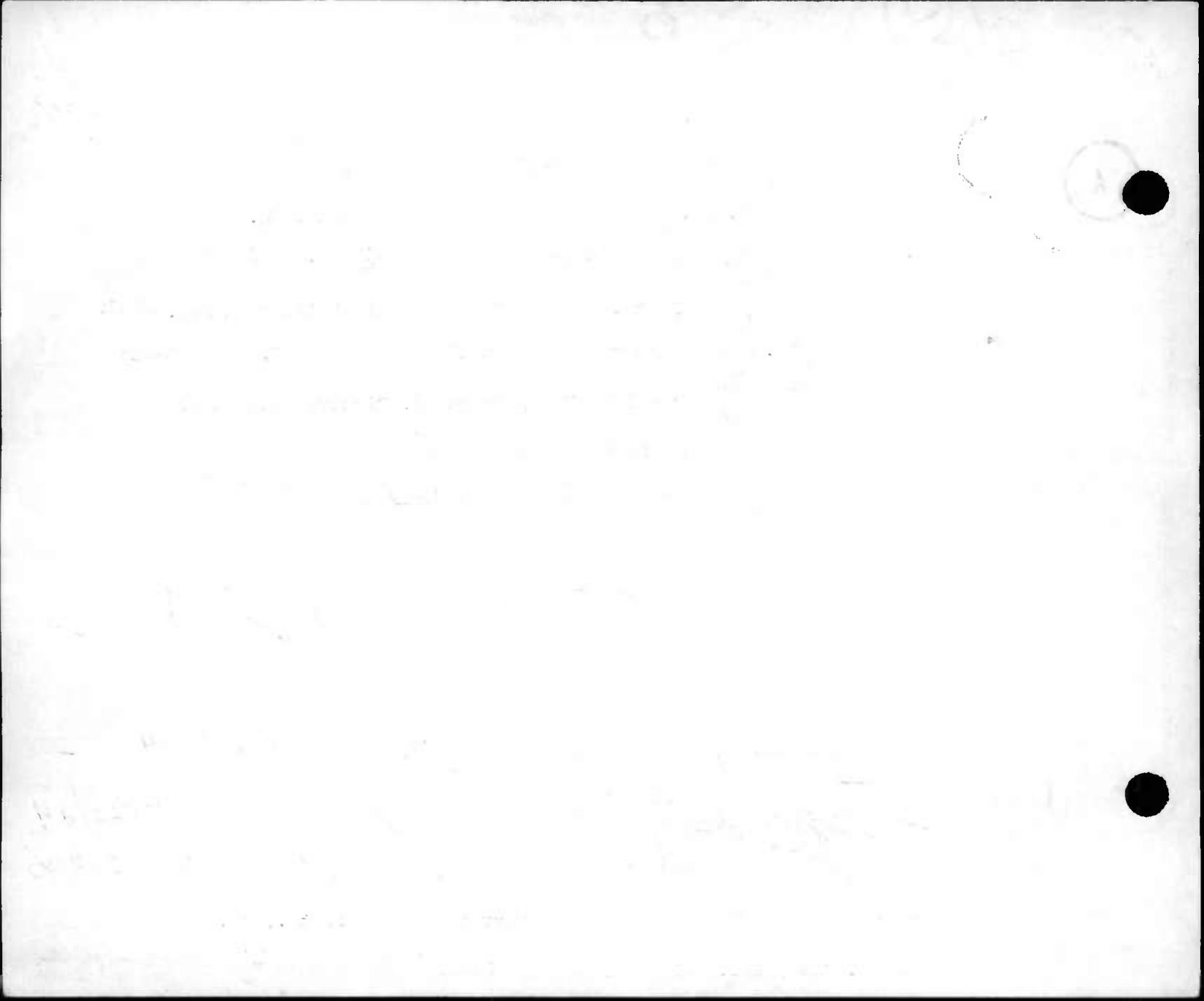
|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William E. Fisher</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 28, 1984</b>                              |  | 2b HOUR<br><b>1230P.M.</b>                                       |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>White</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-4-15</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. Co. MD.</b>                                   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Engineer</b> |  | 12b KIND OF BUSINESS OR INDUSTRY                                 |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE<br><b>1202 Glenwood Ave. 21239</b> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William E. Fisher</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Goldie I. Lewis</b>   |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-01-9687</b>   |   | 17 INFORMANT<br>ADDRESS<br><b>Florence J. Fisher, Same as 13e</b>                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recent Myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>Hiatus Hernia - Coronary insufficiency</b>  |  |  |   |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTHORITY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (I) (the hospital) attended the deceased from <b>7/26</b> to <b>7/28/84</b> that (I) (did not) saw the deceased alive on <b>7/28/84</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.   |  |  |   |  |  |
| 22b SIGNATURE<br><b>Vuong Vu Nguyen</b>   |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>7/28/84</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Vuong Vu Nguyen</b>  |  | 22e ADDRESS<br><b>6331 Belair Rd. Balto Md 21206</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-31-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>  |  | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. 5305 Harford Rd 21214</b>  |   |  |  |
| 25a DATE REC'D. BY REGISTRAR  |  | 25b REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 356-1330.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |                   |   |  |  |  | REG. NO.                                     |  |
|--|--|--|--|--|-------------------|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  | 2a. DATE OF DEATH |   |  |  |  | 2b. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH |   |  |  |  | 2b. HOUR                                     |  |
| MABEL L FLETCHER   |  |  |  |  | 7/16/84           |   |  |  |  | 4:55PM                                       |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 72 HRS.                             |  |
| Female   |  | White  |  | June 17 1916   |                   | 68  |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| Virginia   |  | USA  |  |  |                   | BALTIMORE COUNTY MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |
| TOWSON   |  | 6701 N CHARLES ST GBMC   |  | Housewife  |                   | Homemaker   |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |  |  |
| Md.  |  | Baltimore  |  | Reisterstown   |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 3335 Black Rock Rd., 21136                                     |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |                   |   |  |  |  |  |  |
| Edward Ratcliffe   |  |  |  | Dora Clark   |                   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT ADDRESS   |  |  |  |  |  |
| NO   |  |  |  | 218-62-0334  |                   | Mary Rorke, 3600 Lineboro Rd., Manchester, Md                       |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |                   |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) RESPIRATORY ARREST   |  |  |  |  |                   |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                   |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |                   |   |  |  |  |  |  |
| (b) C.O.P.D.   |  |  |  |  |                   |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                   |   |  |  |  |  |  |
| (c)  |  |  |  |  |                   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |  |  |  |                   |   |  |  |  |  |  |
| C.O.P.D. PNEUMONIA   |  |  |  |  |                   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |  |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                   |   |  |  |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |                   |   |  |  |  |  |  |
|  |  | P.M. 19  |  |  |                   |   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |                   | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | STREET   |                   |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/13 1984, to 7/16 1984, that (I) (we) last saw the deceased alive on 7/16 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not attend the body after death. |  |  |  |  |                   |   |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |                   | DEGREE  |  | 22c. DATE SIGNED   |  |  |  |
| Michael D. Joyce M.D.  |  |  |  |  |                   |   |  | 7/16/84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |                   | 22e. ADDRESS  |  |  |  |  |  |
| DR. M. JOYCE   |  |  |  |  |                   | GBMC  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION   |  | CITY OR TOWN   |  | COUNTY STATE                                 |  |
| Burial   |  | July 19, 1984  |  | Deer Creek UM  |                   | Forest Hill   |  | Harford  |  | Md.  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |                   | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |
| John H. Harkins 600 Main St., Delta, Pa.   |  |  |  |  |                   | JUL 20 1984   |  | John Harkins   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18079

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                                      |   |  |
|--|--|---|--|---|--------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <b>ALLEN</b> MIDDLE LAST <b>FLOWER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>25</b> YEAR <b>84</b> |   | 2b. HOUR<br><b>4<sup>35</sup> AM</b> |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>7</b> YEAR <b>15</b>  |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.<br>IF UNDER 1 YEAR: MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b><br>IF UNDER 24 HRS: MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS.)<br><b>Baltimore County General Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Revere Copper</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>Pasadena</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8448 Greenway Road 21122</b>   |                                      |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Allen</b> MIDDLE LAST <b>Flower</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rita</b> MIDDLE LAST <b>Vandermark</b>   |  |   |                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>189-03-3703</b>  |  | 17. INFORMANT<br><b>Allen R. Flower</b>   |                                      | ADDRESS<br><b>Same as 13e</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>SEPSIS - PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>POSSIBLE MESOTHELIOMA</b> |  |   |  |   |                                      |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |                                      |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/10</b> , 19 <b>84</b> , to <b>7/25</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                                      |   |  |
| 22b. SIGNATURE<br><b>Raymond Depestre</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                      | 22c. DATE SIGNED<br><b>7/25/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYNOLD DEPESTRE</b>   |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GENERAL HOSP.</b>   |  |   |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/28/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>A.A.</b> MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hwy Balto Md</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 30 1984</b>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Randall</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by the State Dept. of Health and Mental Hygiene.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
|--|---------|--|--|---|--|------------------------------------|--|---|--|------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST                               |  | 2a. DATE KNOWN OF DEATH   |  |                              |  | 2b. HOUR  |  |  |  |
| Walter I. Forbes   |         |  |  |   |  |                                    |  | MONTH DAY YEAR<br>7 16 19 84  |  |                              |  | M<br>10:05  |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                     |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD     |  | 2d. HOUR  |  |  |  |
| Male   | White   | MONTH DAY YEAR<br>3 15 00                                |  | LAST BIRTHDAY<br>84 YRS.  |  | MONTHS DAYS                        |  | HOURS MIN.  |  | MONTH DAY YEAR<br>7 16 19 84 |  | M<br>10:05  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                              |  |   |  |  |  |
| VA   |         | USA  |  | WIDOWED   |  | DIVORCED                           |  | Baltimore County  |  |                              |  | MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |                              |  |   |  |  |  |
| Randallstown   |         | 3503 Foxcliff Apts.                                      |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |  |  | 13a. STATE  |  |                                    |  | 13b. COUNTY   |  |                              |  | 13c. CITY OR TOWN   |  |  |  |
|  |         |  |  | MD  |  |                                    |  | Baltimore   |  |                              |  | Randallstown  |  |  |  |
|  |         |  |  | 13d. INSIDE CITY LIMITS?  |  |                                    |  | 13e. STREET ADDRESS   |  |                              |  |   |  |  |  |
|  |         |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                    |  | 3503 Foxcliff Apts. 21133   |  |                              |  |   |  |  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| FIRST MIDDLE LAST  |         | FIRST MIDDLE LAST  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | ADDRESS                            |  |   |  |                              |  |   |  |  |  |
| No   |         | 220-09-8967  |  | Ronald Jones  |  | 3503 Foxcliff Apt.s                |  |   |  |                              |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |  |                                    |  |   |  |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |
| PART 1 DEATH WAS CAUSED BY:  |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| (b)  |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| (c)  |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |                                    |  |   |  |                              |  | 20. AUTOPSY?  |  |  |  |
|  |         |  |  |   |  |                                    |  |   |  |                              |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS  |         |  |  | 21b. TIME OF INJURY   |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                              |  |   |  |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                 |  |                                    |  |   |  |                              |  |   |  |  |  |
| 21d. INJURY OCCURRED   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |  |                                    |  | 21f. LOCATION   |  |                              |  |   |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |         |  |  |   |  |                                    |  | CITY OR TOWN COUNTY STATE   |  |                              |  |   |  |  |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |                                    |  |   |  |                              |  |   |  |  |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)   |  |                                    |  | MEDICAL EXAMINER  |  |                              |  | DATE SIGNED   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS   |  |                                    |  |   |  |                              |  |   |  |  |  |
| Thomas D. Smith, M.D.  |         |  |  | 111 Penn St.  |  |                                    |  | Balto., MD.   |  |                              |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   |  | 23d. LOCATION                |  |   |  |  |  |
| Burial   |         |  |  | 7/18/84   |  | Mt. Zion Cem.                      |  |   |  | Baltimore MD                 |  |   |  |  |  |
| 24. FUNERAL DIRECTOR   |         |  |  | 25a. DATE RECEIVED BY REGISTRAR                                     |  |                                    |  | 25b. REGISTRAR'S SIGNATURE  |  |                              |  |   |  |  |  |
| Wm. C. March F/H   |         |  |  | 1101 E. North Ave.  |  |                                    |  | JUL 18 1984   |  |                              |  | John Davidson-Randall   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

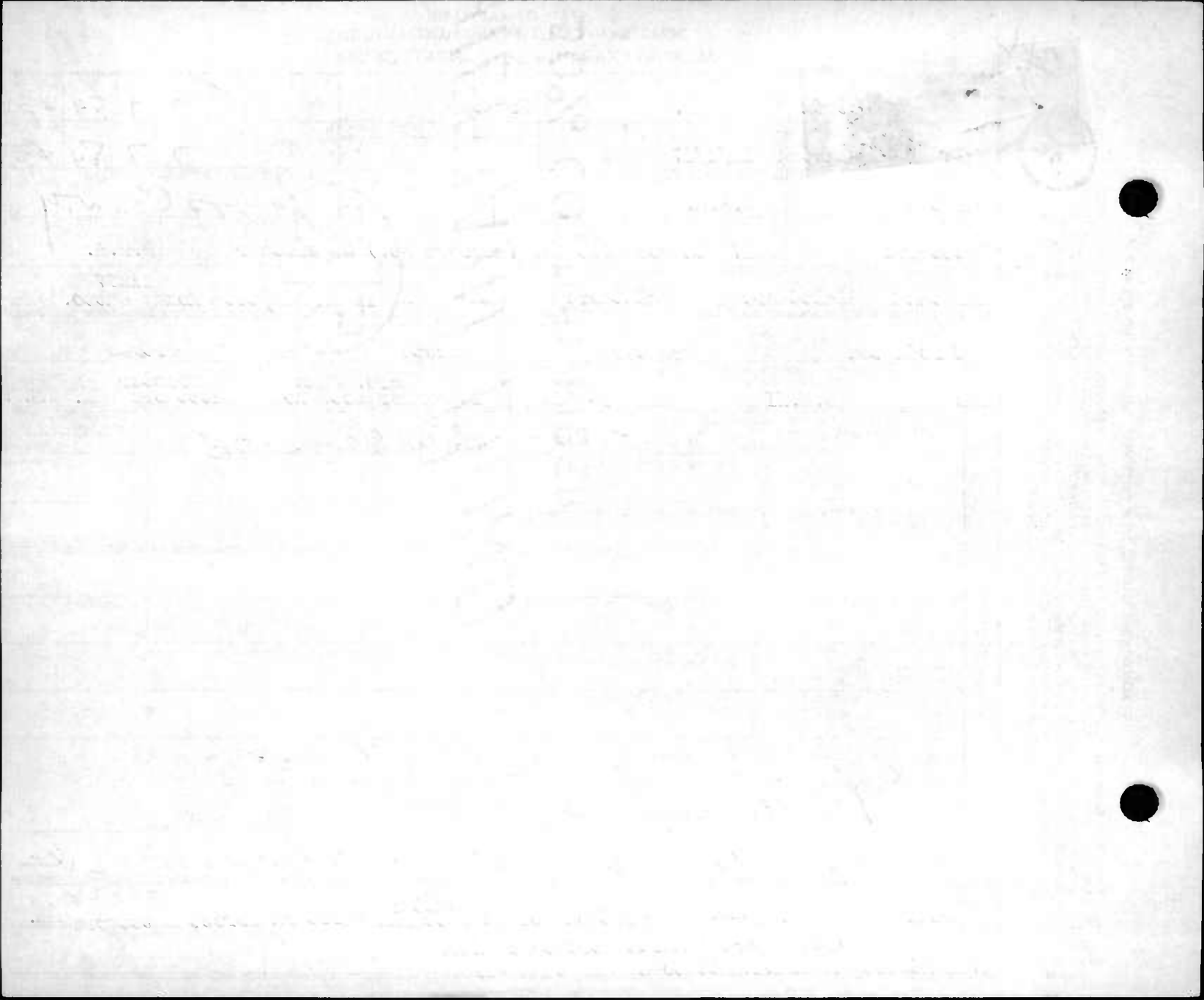
BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                                 |   |  |   |   |  |  |   |                         |
|--|---------------------------------|---|--|---|---|--|--|---|-------------------------|
| 1. DECEASED NAME<br>(LAST OR PRINT) <i>Melvin D. Frazier</i>   |                                 |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>7 7 1984</i><br>DEATH MATED <input type="checkbox"/> MONTH DAY YEAR <i>7 7 1984</i> |   |   | 2b. HOUR<br><i>4:30 PM</i>   |  |   |                         |
| 3. SEX<br><i>Male</i>  | 4. RACE<br><i>Caucasian</i>     | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>11/1/17</i>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <i>66</i> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <i>7 7 1984</i>                         | 2d. HOUR<br><i>4:30 PM</i>   |   |                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County MD.</i>                |  |   |                         |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |                                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>8317 Windsor Mill Rd. (across St.)</i> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Supervisor</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>M.T.A.</i>                                  |                         |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                                 |   |  |   |   |  |  |   |                         |
| 13a. STATE<br><i>Maryland</i>  | 13b. COUNTY<br><i>Baltimore</i> | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS<br><i>12 Summerfield Road</i>   |   |  |  |   | <i>21207 Balto., Md</i> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Carvington Frazier</i>  |                                 |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Bessie May Grimes</i>  |   |   |  |  |   |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <i>Yes</i>   |                                 |   | 16b. SOCIAL SECURITY NO.<br><i>W.W.II 214-01-0859</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Mrs. June Frazier 12 Summerfield Road Baltimore, Md. 21207</i> |  |  |   |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>SUICIDE - CARBON MONOXIDE</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                 |   |  |   |   |  |  |   |                         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                                 |   |  |   |   |  |  |   |                         |
| 19a. DATE OF OPERATION   |                                 |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                 |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                 |  |  |   |                         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                                 |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |                         |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                                 |   |  |   |   |  |  |   |                         |
| ACTUAL SIGNATURE<br><i>E. P. Williamson</i>  |                                 |   | TITLE (SPECIFY)<br>M.D.  |   |   | MEDICAL EXAMINER<br>DATE SIGNED  |  |   |                         |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <i>E. P. Williamson</i>   |                                 |   | ADDRESS <i>5550 BALTO. NAT'L RD</i>  |   |   |  |  |   |                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>Burial</i>   |                                 |   | 23b. DATE<br><i>7-10-84</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cemetery Garrison Forest Veterans</i>                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Garrison Forest Baltimore Md.</i> |   |                         |
| 24. FUNERAL DIRECTOR<br>NAME <i>Loring Byers</i>   |                                 |   | ADDRESS <i>8728 Liberty Road Randallstown, Maryland 21133</i>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>11/13/84</i>                                   |  | 25b. REGISTRAR'S SIGNATURE  |                         |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 8 2

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Thomas E. Frazier Jr.   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 20, 1984   |  |
| 3. SEX<br>Male  |  | 2b. HOUR<br>1 A.M.  |  |
| 4. RACE<br>White  |  | 6. AGE (IN YEARS, LAST BIRTHDAY) YRS. MONTHS DAYS<br>46   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>12-21-37   |  | 8. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>405 Hammershire Rd. |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Fireman  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Fire Dept.   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  |
| 13c. CITY OR TOWN<br>Owings Mill  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 13e. STREET ADDRESS<br>405 Hammershire Rd.  |  | 2117  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas E. Frazier Sr.  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Dora Cavey  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>214-34-4474   |  |
| 17. INFORMANT<br>Veronica Frazier   |  | ADDRESS<br>405 Hammershire  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>severe obstructive jaundice + uremia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>hepatorenal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic colon carcinoma</u>       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 months<br>4 months<br>2 years   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>bleeding diathesis</u>   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                        |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br>STREET   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/7/84</u> to <u>7/18/84</u> , that (I) (we) lost saw the deceased alive on <u>7/18/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><u>Ruth Kantor</u>  |  | 22c. DATE SIGNED<br>7/20/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ruth Kantor MD   |  | 22e. ADDRESS<br>UMCC 225. Greene St. Balto, 21201   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>7/23/84  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Lakeview Memorial   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Sykesville, Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>Eline Funeral Home Reisterstown Md.  |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JUL 24 1984 Julia Davidson-Randall                                 |  |

BP

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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Bureau of Plant Industry  
Washington, D. C.

Plant Industry

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

JUL 24 1912



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418083

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELSIE M. FREITAG</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 11 '84</b>               |   |   | 2b. HOUR<br><b>1:33A</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>MARCH 7, 1907</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTO. MEDICAL CENTER</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECRETARY</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ELECTRIC</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>5537 CEDONIA AVENUE 21206</b>                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>KARL FREITAG</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARTHA KRAFT</b> |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215 10 4058</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>FORK SHIRLEY SESSIONS 6508 UPLAND RD. MARYLAND</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASYSTOLE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE CEREBRAL ACCIDENT-BRAINSTEM</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>versus accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>9 HOURS</b> |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19 84</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-09</b> , 19 <b>84</b> , to <b>7-11</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7-11</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert Prince</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |   |  |  | 22c. DATE SIGNED<br><b>7/11/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT PRINCE, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARELS ST.</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>7/14/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SECURITY PROCESS</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BAL TIMORE MARYLAND</b>             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>DIPPEL FUNERAL HOMES INC. 7110 BELAIR RD. BALTO. MD.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 13 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                           |  |  |  |

MEDICAL CERTIFICATION



BRIDGE OF GREAT ROCKETS, BANGOR, N. I.

1914

CHURCH ST.

POST OFFICE

1914

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

BP  
DHMH - 17  
(FRA 15 ME (5))  
15M/77

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |  |  |  |  |   |  | REG. NO. 18084   |  |  |  |
|---|--|------------------|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Ernst Karl Fritze  |  |                  |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>7 9 1984                |  | 2b. HOUR<br>152 PM   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 14 07   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>76 YRS.                  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>7 9 1984               |  | 2d. HOUR<br>152 PM   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Germany  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Germany  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO - COUNTRY MD.          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3431 Barry Paul RD |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Caretaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>School                          |  |  |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Randallstown                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>3431 Barry Paul RD                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Paul Fritze   |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maria Glaeser |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-38-7323   |  | 17. INFORMANT<br>ADDRESS<br>Margarete H. Fritze                |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gunshot Wound to Temple<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>E. P. Williamson  |  |                  |  | TITLE (SPECIFY)<br>M.D. Deputy   |  |  |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>7/9/84  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>E. P. Williamson  |  |                  |  | ADDRESS<br>5550 BALTO. NAT'L K 21228   |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>7-13-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Cemetery       |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Eldersburg Carroll MD. |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Harry W. Haight, Sykesville MD   |  |                  |  |  |  |  |  |   |  |  |  |  |  |
| 25. DATE REC'D. BY REGISTRAR<br>JUL 11 1984   |  |                  |  |  |  |  |  |   |  |  |  |  |  |
| 26. REGISTRAR'S SIGNATURE<br>John Davidson  |  |                  |  |  |  |  |  |   |  |  |  |  |  |

RECEIVED  
CENTRAL RECORDS & COMMUNICATIONS DIVISION  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Walter Guy Gable |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07 07 84                              |   | 2b. HOUR<br>535 P.M.   |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09 29 06  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                        | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>mechanic |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Automobile                  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Towson  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>21204<br>29 C DUNVALE RD.                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Guy Gable                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ellia Feldinger  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-07-1440  |  | 17. INFORMANT<br>ADDRESS<br>Page M. Gable 29 C DUNVALE RD<br>Towson, MD. 21204                  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SMALL BOWEL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) PANCREATIC TUMOR<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

|  |  |  |   |
|--|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Renal Failure   |  |  |   |
| 19a. DATE OF OPERATION<br>7/7/84   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>INFARCT BOWEL      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/5 6/22 19 84 to 7/7 19 84, that (I) (we) lost<br>saw the deceased alive on 7/5 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Graham Falken  |  | 22c. DATE SIGNED<br>7/7/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GRAHAM FALKEN   |  | 22e. ADDRESS<br>7600 OSLER DR.   |   |

|   |                           |  |  |
|---|---------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION | 23b. DATE<br>July 9, 1984 | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>H. J. Edlauff             |                           | 25a. DATE REC'D. BY REGISTRAR<br>10 1984                 |  |
| ADDRESS<br>Owings Mills, Md.                              |                           | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall      |  |

[illegible]

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18086

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jean</b>                                |  |  | 3. SEX<br><b>FEMALE</b>  |  |  | 4. RACE<br><b>WHITE</b>   |  |  | 5. DATE OF BIRTH<br>MONTH <b>FEB.</b> DAY <b>11,</b> YEAR <b>1913</b>                           |  |  | 2a. DATE OF DEATH<br>MONTH <b>7-</b> DAY <b>17-</b> YEAR <b>84</b>                   |  |  | 2b. HOUR<br><b>1<sup>st</sup> P.M.</b>          |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>                 |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS <b>71</b> DAYS <b>17</b>                                   |  |  | IF UNDER 24 HRS<br>HOURS <b>1</b> MIN. <b>0</b> |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                     |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                  |  |  |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTO.</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>6601 BAYTHORNE RD. #21209</b>                              |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>MORRIS</b> MIDDLE <b>GROSS</b> LAST <b>GROSS</b> |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>FANNIE</b> MIDDLE <b>BERSACK</b> LAST <b>BERSACK</b>   |  |  |   |  |  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b> |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>152-1 0-2152</b>   |  |  |   |  |  | 17. INFORMANT <b>MRS. RUTH HOFFMAN</b><br><b>6601 BAYTHORNE RD. BALTO., MD 21209</b> |  |  |   |  |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Cancer of Liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>1 P</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-15</b> , 19 <b>84</b> , to <b>7-17</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7-</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Eddie Nakhuda MD</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7/17/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eddie Nakhuda MD</b>   |  |  |  | 22e. ADDRESS<br><b>Stella Maris Hospice</b>   |  |  |  |

|   |  |                                   |  |  |  |   |  |
|---|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>JULY 19, 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME <b>16010 REISTERSTOWN RD. BALTO., MD</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 23 1984</b>      |  | 25b. REGISTRAR'S SIGNATURE<br><b>Carla Swanson-Rodriguez</b>                |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



U.S. DEPT. OF AGRICULTURE

BOX COTTON

JUL 2 1954



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 8 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |              |  |  |  |  |  |
|---|--------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PHILLIP DELCHER GAMBRILL   |              |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07 01 84              |  | 2b. HOUR<br>8:57p M                                    |  |
| 3. SEX<br>M   | 4. RACE<br>W | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 27 29   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND<br>BALTIMORE  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>COUNTY BALTIMORE MD  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESMAN   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>COULTER   |
| 13a. STATE<br>MD  |              | 13b. COUNTY<br>BALTO   | 13c. CITY OR TOWN<br>TOWSON                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      | 13e. STREET ADDRESS / ZIP CODE<br>205 E JOPPA RD 21204 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HAROLD F. GAMBRILL  |              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FAY DELCHER |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>136-22-8634   |  | 17. INFORMANT<br>ADDRESS<br>MARY VERONICA GAMBRILL SAME  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>HAASCD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Years</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |              |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |              |  |  |  |  |  |
| 19a. DATE OF OPERATION  |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1984, to July 1, 1984, that (I) (we) last saw the deceased alive on July 1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.  |              |  |  |  |  |  |
| 22b. SIGNATURE<br>L. Hernandez  |              |  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. Hernandez M.D.   |
| 22e. ADDRESS<br>7600 Osier Med Center   |              |  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION   |              | 23b. DATE<br>JULY 3, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREENMOUNT   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY, MARYLAND   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MITCHELL-WIEDEFELD HOME, INC. BALTO., MD. 21212   |              |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 3 1984  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Harrison  |              |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



07 01 84

GABRIEL

PHILIP

22

06 27 29

W

M

COUNTY

BALTIMORE

SALESMAN

ST. JOSEPH HOSPITAL

THOMAS

FABRICS

205 E 40TH RD

TOWSON

BALTO

MD

13C-22-8834

Q150

JUL 1 1984

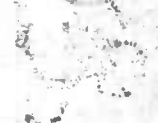
1984

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |         |  |  |   |                              |   |   |                                   |   |
|--|---------|--|--|---|------------------------------|---|---|-----------------------------------|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |   |                              |   |   |                                   |   |
| REG. NO.   |         |  |  |   |                              |   |   |                                   |   |
| Item #16b Film #G594<br>1- STATE REGISTRAR Items 18-22a #520 8/27/84   |         |  |  |   |                              |   |   |                                   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  |  |   |                              | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR                          |   |
| Ronald Whitney Ganges  |         |  |  |   |                              | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br>7 25 1984 |   | 3:54 PM                           |   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  |                              | IF UNDER 24 HRS.  |   | 7c. DATE PRONOUNCED DEAD          |   |
| Male   | Black   | 12 22 53   | 30 YRS.  | MONTHS DAYS HOURS MIN.  |                              |   |   | 7 25 1984                         |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |                                   |   |
| Maryland   |         | U.S.A.   |  |   |                              | Baltimore County, MD.   |   |                                   |   |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| Essex  |         | Franklin Square Hospital   |  |   |                              | Active Duty   |   | US Navy                           |   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |  |  |   |                              |   |   |                                   |   |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                              | 13d. INSIDE CITY LIMITS?  |   |                                   |   |
| Maryland   |         | Baltimore  |  | Baltimore   |                              | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |                                   |   |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)   |         |  |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)   |                              |   |   |                                   |   |
| Roland Ganges  |         |  |  | Vashti Williams   |                              |   |   |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |                              | 17. INFORMANT ADDRESS   |   |                                   |   |
| Yes  |         |  |  | Active Service 215-60-52820   |                              | Sandra Ganges 26 Walden Laurel Crt. Baltimore, Md.  |   |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:   |         |  |  |   |                              |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <u>Acetaminophen intoxication</u>  |         |  |  |   |                              |   |   |                                   |   |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |                              |   |   |                                   |   |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |   |                              |   |   |                                   |   |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |                              |   |   |                                   |   |
| (c)  |         |  |  |   |                              |   |   |                                   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |                              |   |   |                                   |   |
| 19a. DATE OF OPERATION   |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                        |   |                              |   |   |                                   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 7/20 1984        |   |                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                     |   |                                   |   |
|  |         |  |  |   |                              | ingestion of drugs  |   |                                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>apartment |   |                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>9813 Maple Crest Apt. H Essex, Md.                           |   |                                   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |                              |   |   |                                   |   |
| ACTUAL SIGNATURE   |         |  | TITLE (SPECIFY)  |   |                              |   | DATE SIGNED                               |                                   |   |
| Margarita A. Korell, M.D.  |         |  | Assistant MEDICAL EXAMINER   |   |                              |   | 7/26/84                                   |                                   |   |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  | ADDRESS  |   |                              |   |   |                                   |   |
|  |         |  | 111 Penn St. Balto., MD.   |   |                              |   |   |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CRE |   | 23d. LOCATION (CITY OR TOWN COUNTY STATE) |                                   |   |
| Removal  |         |  | 7/30/1984  |   | Meadowridge Memorial Pk.     |   | Baltimore Maryland                        |                                   |   |
| 24. FUNERAL DIRECTOR NAME  |         |  | ADDRESS  |   | 25a. DATE RECD. BY REGISTRAR |   | 25b. REGISTRAR'S SIGNATURE                |                                   |   |
| Marshall's Funeral Home  |         |  | 4217 9th St. NW Wash., DC 20011  |   | JUL 31 1984                  |   | Margarita A. Korell                       |                                   |   |

BP 818



NOTICE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 8 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |                             |   |  |
|---|--|--|---|---|-----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Baby Girl GELWICKS</i> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>7/27/84</i> |   | 2b. HOUR<br><i>12:33 AM</i> |   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>7/26/84</i>  |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><i>27</i> |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Md.</i>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>MD.</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto</i>                                      |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>St. Joseph</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                             | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><i>Md.</i>  |  |  |   | 13b. COUNTY<br><i>Balto</i>   |                             | 13c. CITY OR TOWN<br><i>Balto</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charles C. GELWICKS</i>                  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Shella Mcabee</i>   |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>ADDRESS  |                             |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *IMMATUREITY*

DUE TO, OR AS A CONSEQUENCE OF

(b) *SPONTANEOUS PREMATURE RUPTURE OF MEMBRANES*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
*< 1 HR.**4 DAYS.*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

*HEMORRHAGE, LEFT LATERAL VENTRICLE, BRAIN. PLACENTAL + MEMBRANE INFLAMMATION.*

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><i>NO</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/26</i> , 19 <i>84</i> , to <i>7/27</i> , 19 <i>84</i> , that (I) <input checked="" type="checkbox"/> last<br>saw the deceased alive on <i>7/27</i> , 19 <i>84</i> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If two physicians saw the body after death.) |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |  |  | DEGREE<br><i>M.D.</i>  |  | 22c. DATE SIGNED<br><i>7/30/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JAMES W. EAGAN, JR., MD.</i>  |  |  |  | 22e. ADDRESS<br><i>DEPT PATH, ST. JOSEPH HOSP, TOWSON, MD 21204</i>                  |  |  |  |

|  |  |                             |  |   |  |  |  |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>REMOVAL</i> |  | 23b. DATE<br><i>7-30-84</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>[Redacted]</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>ST. JOSEPH FUNERAL HOME</i> |  |                             |  | ADDRESS<br><i>1602 YORK RD TOWSON 21204</i>             |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

AUG 20 1984  
*[Signature]*

12-3-11 14704138  
02-11-11 14704138  
12-3-11 14704138



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 9 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DORIS M. GEMELLARO</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 - 11 - 84</b>                            |   | 2b. HOUR<br><b>5:25 AM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 - 24 - 1923</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Towson</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1582 Cottage Lane 21204</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William O. Fisher</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Meta</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>W.W. 11 215-12-4331</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Santo P. Gemellaro, Sr. Balto., MD 21204</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 HRS.</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |   |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>PERIPHERAL ARTERIAL INSUFFICIENCY</b>   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-10</b> 19 <b>84</b> , to <b>7-11</b> 19 <b>84</b> , that (we) lost<br>saw the deceased alive on <b>7-11</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) not view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Albert J. Diaz</b>  |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>7/11/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALBERTO J. DIAZ M.D.</b>   |   | 22e. ADDRESS<br><b>7600 OSCAR DR., TOWSON, MD.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>July 14, '84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>  |   | ADDRESS<br><b>8521 Loch Raven Blvd</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 12 1984</b>   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 4 1 8 0 9 1  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>AIBERT H. GENESE</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>07 19 84</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 31 98</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><b>86</b> YRS. MONTHS DAYS HOURS MIN.<br><b>3 19</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>London, England</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville, Md</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MO. MASONIC HOME</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sea Captain</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shipping</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>DAVID GENESE</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>KATIE Esthor HOW</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>111 West Maple St. 21043</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-1516</b>  |  | 17. INFORMANT ADDRESS<br><b>Md Masonic Home Cockeysville, MD 21030</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastrointestinal Bleed</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Uremia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis</b> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Multiple Strokes</b>  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>July 19, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.                                      |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Pm Rivas</b>  |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>7-19-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Pm Rivas</b>   |  |   |  | 22e. ADDRESS<br><b>Maryland masonic Homes</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-20-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Christ Epis. Ch.Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>St. Michaels Talbot Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Mithhell-Wiedefeld Home 6500 York Road 21212</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 24 1984</b>  |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418092

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |  |   |   |   |   |
|---|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Henry A. Geyer</b> |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 18 84</b>   |   | 2b. HOUR<br><b>4<sup>30</sup> AM</b>                            |   |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 22 1903</b>                |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>—</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto County</b> MD. |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOR CARE-Ruxton</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Shipping Clerk</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Welding Rd</b>          |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>—</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>21224 116 N. Potomac Street</b>       |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Oscar Geyer</b>                      |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Ruehling</b> |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |   | 16b. SOCIAL SECURITY NO.<br><b>212-01-1978</b>                         |   | 17. INFORMANT ADDRESS   |   |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF BLADDER.</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTASIS.</b>  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>7/18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Parra</b>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>7/19/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. E. PARRA.</b>   |  | 22e. ADDRESS<br><b>7122 HARFORD RD.</b>                                |  |  |   |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                  | 23b. DATE<br><b>7-20-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk - Balto. Co. - Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John A. Moran, Inc - 3000 E. Balto. St.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 20 1984</b>            |   |
|  |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>    |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1/10/54

7125 HARFORD RD.

C. C. PARKER  
BY

METASTASIS  
GROWTH OF BLADDER

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 4 1 8 0 9 3

FOR  
 STATE  
 REGISTRAR

REG. NO.

|   |  |  |   |   |                            |  |
|---|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Louis GILBERT</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>7 10 84</i> |   | 2b. HOUR<br><i>8:45 AM</i> |  |
| 3. SEX<br><i>MALE</i>   |  | 4. RACE<br><i>W HITE</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4-16-09</i>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>75</i> YRS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>POLAND</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE COUNTY</i> MD.  |
| 10. CITY OR TOWN OF DEATH<br><i>RANDALLSTOWN</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>BALTIMORE COUNTY GEN. HOSP.</i> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>MERCHANT</i>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>RETAIL</i>   |
| 13a. STATE<br><i>MARYLAND</i>   |  | 13b. COUNTY<br><i>BALTIMORE</i>  |   | 13c. CITY OR TOWN<br><i>BALTIMORE</i>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>HARRY GILBERT</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>FANNIE UNKNOWN</i>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>YES</i>  |                            | 16b. SOCIAL SECURITY NO.<br><i>143-09-3212</i>   |
| 17. INFORMANT<br><i>MRS. FLORENCE GILBERT</i>   |  | 18. ADDRESS<br><i>2909-F TERRY DR. BALTO., MD</i>  |   | 19. ZIP CODE<br><i>21209</i>  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Inferior Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (i)   |  |  |   |   |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7-10 19 84</i> to <i>7-10 19 84</i> , that (I) (we) last saw the deceased alive on <i>7-10 19 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |                            |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE<br><i>MD</i>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                            | 22c. DATE SIGNED<br><i>7-10-84</i>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>R. DEPESTRE</i>   |  | 22e. ADDRESS<br><i>BALTIMORE COUNTY GENERAL HOSP</i>   |   |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>JULY 12, 1984</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>BNAI ISRAEL (MISHKON ISRAEL SEC.)</i>  |                            | 23d. LOCATION<br>CITY COUNTY STATE<br><i>BALTIMORE MARYLAND</i>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>SOL LEVINSON &amp; BROS., INC.</i>   |  | ADDRESS<br><i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>   |   | 25. DATE REC'D. BY REGISTRAR<br><i>JUL 17 1984</i>  |                            |  |
| 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |   |   |                            |  |

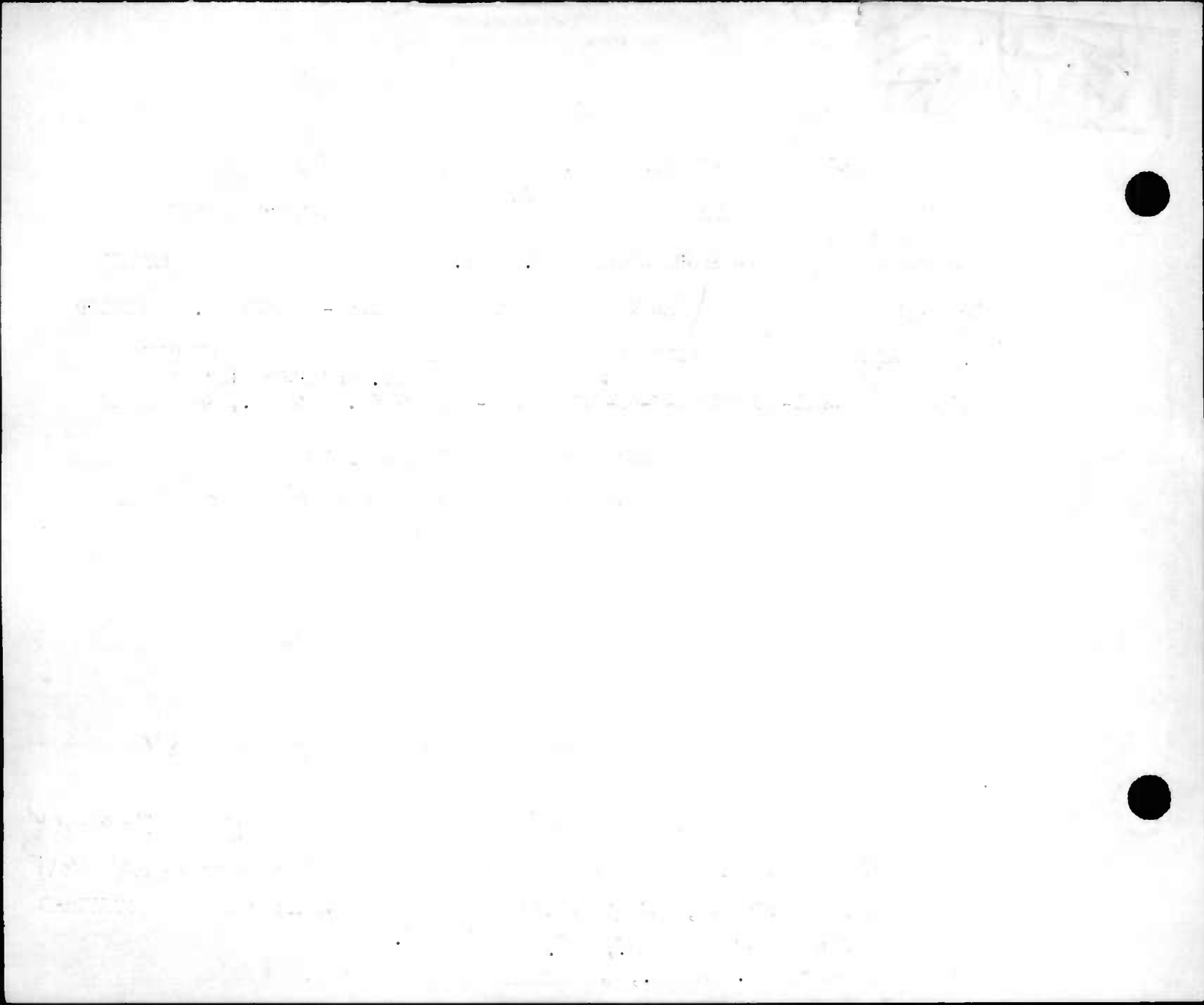
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 9 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |                                |   |  |   |  |                                  |  |
|---|--|--|---|--|--------------------------------|---|--|---|--|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret H. GLOS   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 2, 1984 |  | 2b. HOUR<br>5:55P <sub>M</sub> |   |  |   |  |                                  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>June 16 <sup>th</sup> 1913 <sup>AR</sup>   |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 <sup>YRS.</sup>                   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.      |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |
| 9. BIRTHPLACE<br>Maryland   |  | 10. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 12. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.           |  |   |  |                                  |  |
| 13. CITY OR TOWN OF DEATH<br>Rossville 21237  |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Franklin Sq. Hospital |   |  |                                | 15. USUAL OCCUPATION<br>(10% OF WORK FOR MOST OF WORKING LIFE)<br>Clerk |  | 16. KIND OF BUSINESS OR INDUSTRY<br>Insurance Co. |  |                                  |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE Maryland 17b. COUNTY Baltimore 17c. CITY OR TOWN Essex  |  |  |   |  |                                |   |  |   |  |                                  |  |
| 18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 19. STREET ADDRESS / ZIP CODE 812 N. Woodlynn Rd. 21221   |  |  |   |  |                                |   |  |   |  |                                  |  |
| 20. FATHER'S NAME<br>John Souders   |  |  |   |  |                                | 21. MOTHER'S MAIDEN NAME<br>Mary Cullum                                 |  |   |  |                                  |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No  |  |  |   | 23. SOCIAL SECURITY NO.<br>219 03 5356   |                                | 24. INFORMANT<br>William J. Glos, Husband                               |  |   |  | 25. ADDRESS<br>Same              |  |
| 26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute Myocardial Infarction<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |                                |   |  |   |  |                                  |  |
| 27. MEDICAL CERTIFICATION<br>19a. DATE OF OPERATION<br>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/><br>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19<br>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK<br>21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>22a. I certify that (this hospital) attended the deceased from June 27, 1984, to July 2, 1984, that (we) last saw the deceased alive on July 2, 1984, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.<br>22b. SIGNATURE DEGREE<br>22c. DATE SIGNED<br>22d. PHYSICIAN'S NAME (TYPE OR PRINT) BA YIN OUNG<br>22e. ADDRESS 8022 BELAIR ROAD BACTO. Md. 21236<br>23a. BURIAL, CREMATION, REMOVAL Burial<br>23b. DATE 7/6/84<br>23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery<br>23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.<br>24. FUNERAL DIRECTOR Bruzdinski Funeral Home PA 1407 Old Eastern Ave<br>25. DATE REC'D. BY REGISTRAR 3 1984 |  |  |   |  |                                |   |  |   |  |                                  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |        |  |  |   |  |   |  |   |  |  |  |   |  |  |  |
|---|--------|--|--|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |        | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | <input checked="" type="checkbox"/> MONTH DAY YEAR |  | 2b. HOUR  |  |  |  |
| HUGO  |        | C.   |  | GOERGES   |  |   |  | July 16, 1984   |  |  |  | M   |  |  |  |
| 3 SEX   | 4 RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                                    |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD                           |  | 2d. HOUR  |  |  |  |
| Male  | White  | June 14, 1918  |  | 66  |  | YRS.  |  |   |  | July 16, 1984                                      |  | :50 AM  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |        | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | <input checked="" type="checkbox"/> NEVER MARRIED |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |   |  |  |  |
| New York  |        | U.S.A.   |  | WIDOWED   |  | <input type="checkbox"/> DIVORCED                 |  | Baltimore County,   |  |  |  | MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |   |  |  |  |   |  |  |  |
| 21234   |        | 8513 Willow Oak Road                                     |  | Specification   |  | Writer  |  | Fed. Govt.  |  |  |  |   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |        |  |  | 13a. STATE  |  |   |  | 13b. COUNTY   |  |  |  | 13c. CITY OR TOWN   |  |  |  |
| Maryland  |        |  |  | Baltimore   |  |   |  | 21234   |  |  |  |   |  |  |  |
| 14. FATHER'S NAME   |        |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |   |  |   |  |  |  |   |  |  |  |
| Hugo  |        |  |  | Minnie  |  |   |  | M.  |  |  |  | Ziehn   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |        |  |  | 16b. SOCIAL SECURITY NO.                                      |  |   |  | 17. INFORMANT   |  |  |  | ADDRESS   |  |  |  |
| No  |        |  |  | 215-09-1393   |  |   |  | Edith D. Goerges  |  |  |  | 8513 Willow Oak Rd. 21234   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:  |        |  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>  |        |  |  |   |  |   |  |   |  |  |  | Sudden  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |        |  |  |   |  |   |  |   |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |        |  |  |   |  |   |  |   |  |  |  |   |  |  |  |
| (b) <u>Myocardial Ischemia</u>  |        |  |  |   |  |   |  |   |  |  |  | 2+ yrs  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |        |  |  |   |  |   |  |   |  |  |  |   |  |  |  |
| (c) <u>Generalized Atherosclerosis</u>  |        |  |  |   |  |   |  |   |  |  |  | 5+ yrs  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |        |  |  |   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |        |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |   |  |   |  |  |  | 20. AUTOPSY?  |  |  |  |
|   |        |  |  |   |  |   |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |        |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |  |  |  |
|   |        |  |  | P.M. 19   |  |   |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |        |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |   |  |  |  |
|   |        |  |  |   |  |   |  |   |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |        |  |  |   |  |   |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE  |        |  |  | TITLE (SPECIFY)   |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED   |  |  |  |
| Charles F. O'Donnell, M.D.  |        |  |  | 7501 York Rd. 21204   |  |   |  | 823-3161  |  |  |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |        |  |  | ADDRESS   |  |   |  |   |  |  |  |   |  |  |  |
| Burial  |        |  |  | July 18, '84  |  |   |  | Moreland Mem. Park  |  |  |  | Baltimore Co., MD.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |        |  |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |
| Burial  |        |  |  | July 18, '84  |  |   |  | Moreland Mem. Park  |  |  |  | Baltimore Co., MD.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |        |  |  | ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| William E. Johnson  |        |  |  | 8521 Loch Raven Blvd.   |  |   |  | JUL 17 1984   |  |  |  |   |  |  |  |

*[Faint, illegible handwritten notes and markings are visible across the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DMMH - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 84 18096   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Mary Catherine Goldring</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>7 23 84</b>  |  |   |  |
| 3. SEX <b>Female</b>   |  |   |  | 2b. HOUR <b>12<sup>04</sup> P.M.</b>   |  |   |  |
| 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 24 52</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>32</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Garfield Goldring</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn Braxton</b>  |  | 13e. STREET ADDRESS <b>21212</b>   |  | 13f. STREET ADDRESS <b>404 E. Coldspring Lane</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unknown</b>   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS <b>Evelyn Goldring 5220 York Rd. Apt. 6R</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>Cardiac Arrest</b>  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>  |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Arrest</b>   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Isolated Myocardial Infarction</b>   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/23/84</b> to <b>7/23/84</b> , that (I) (we) last saw the deceased alive on <b>7/23/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>WILFSON</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILFSON</b>   |  | 22e. ADDRESS <b>PO 66 Garrison 21055 MD</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>  |  | 23b. DATE <b>7/28/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, MD.</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>  |  |

CHIEF  
W. H. DAVIS

10% COTTON

100 S. 2. 100

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18097

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |                                   |  |   |
|--|---|---|--|--|-----------------------------------|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |                                   | 2b. HOUR   |   |
| GLADYS   |   | GOLDSTONE   |  | July 8, 84   |                                   | 5:40 PM  |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                      |   |
| FEMALE   | WHITE   | FEB. 2, 1907  |  | 77   |                                   |  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |  |   |
| MARYLAND   | USA   |   |  | BALTIMORE COUNTY   |                                   |  |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |
| RANDALLSTOWN   | BALTIMORE COUNTY GEN. HOSP.   |   | BUYER  |  | RETAIL DEPT.                      |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |                                   | STORE  |   |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | YES <input type="checkbox"/> NO <input type="checkbox"/>         | 3601 FORDS LA.   |                                   | #21215   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |                                   |  |   |
| MEYER GOLDSTONE  |   | UNKNOWN   |  |  |                                   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |                                   | ADDRESS  |   |
| NO   |   | 216-01-5822   |  | MRS. CAROLE WILDER   |                                   | 4109 PRISCILLA LA. BALTO., MD 21208                            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:   |   |   |  |  |                                   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Coronary heart failure</u>  |   |   |  |  |                                   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |  |  |                                   |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |   |   |  |  |                                   |  |   |
| (b) <u>chronic renal failure</u>   |   |   |  |  |                                   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |  |  |                                   |  |   |
| (c)  |   |   |  |  |                                   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |   |   |  |  |                                   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |
|  |   |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                   |  |   |
|  |   |   |  |  |                                   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 29, 1984</u> to <u>July 8, 1984</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |  |  |                                   |  |   |
| 22b. SIGNATURE   |   | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED   |   |
| <u>Shamoun Pourmotabed, M.D.</u>   |   |   |  |  |                                   | 7-8-84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |  |  |                                   |  |   |
| GHASSEM POURMOTABED  |   | Balto. Co. General Hospital   |  |  |                                   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION  |   |
| BURIAL   |   | JULY 9, 1984  |  | BNAI ISRAEL (MISHKON ISRAEL SEC.)  |                                   | BALTIMORE, MD  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |   |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |                                   |  |   |
| SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |   |   |  | JUL 10 1984 <u>John Davidson</u>   |                                   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, try the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

20% COTTON FIBRE

CHIFFON



Handwritten text on lined paper, including dates like 'JUL 1 1964' and 'JUL 1 1964', and various illegible notes.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 9 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

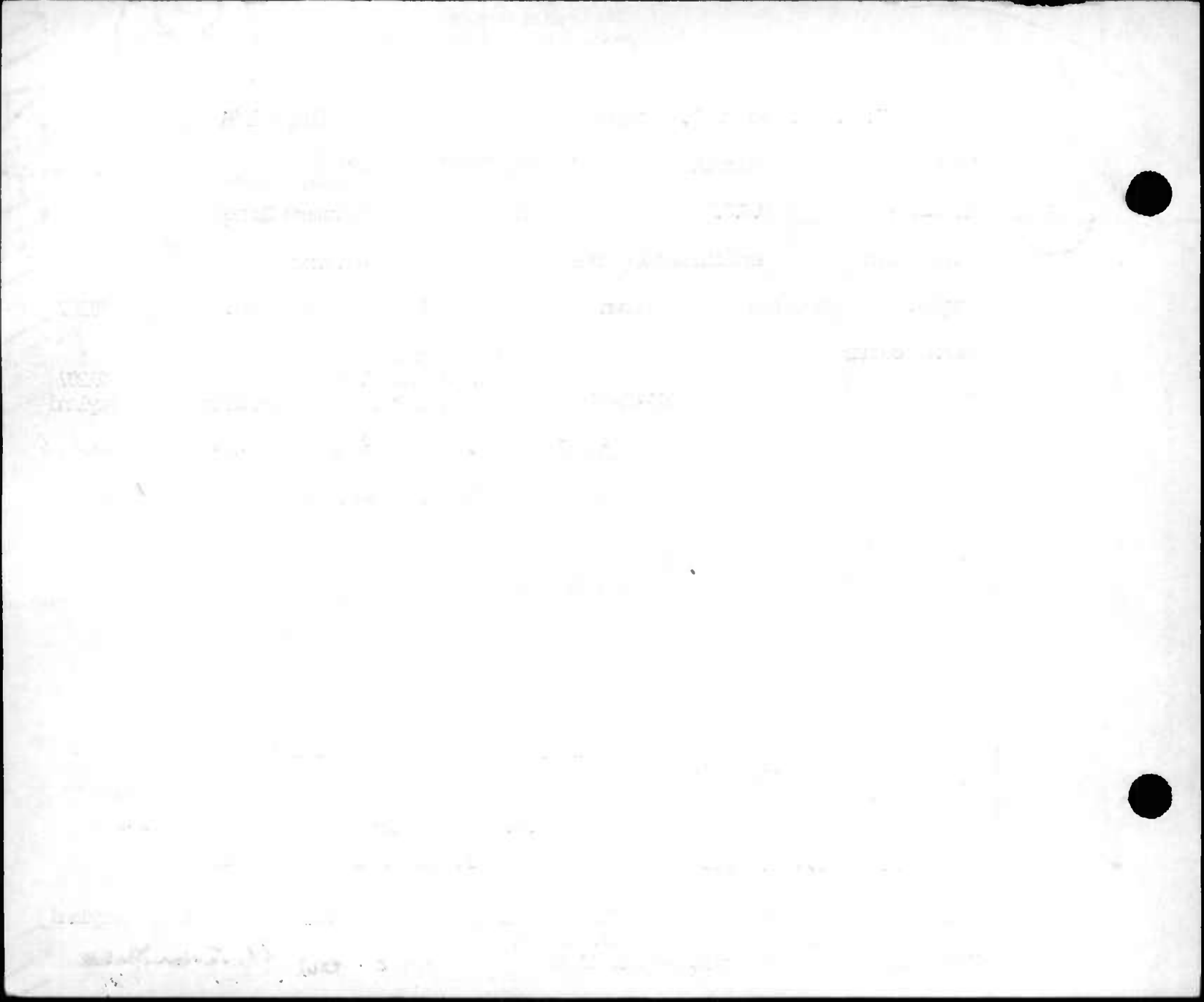
|   |  |   |   |   |                            |   |   |
|---|--|---|---|---|----------------------------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mrs. Rebecca O. Gonzalez</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 4 1984</b> |   | 2b. HOUR<br>AM<br><b>M</b> |   |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 6 1896</b>  |                            | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>88</b> YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mexico</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Woodlawn</b>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Urbano Ordonez</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Morina Flores</b>   |   | 16. STREET ADDRESS / ZIP CODE<br><b>7001 Paris Road 21207</b>   |                            |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>455-03-8699 A</b>  |   | 17. INMATE ADDRESS<br><b>Mrs. Herlinda C. Yutzy 21207</b>   |                            | 17b. CITY OR TOWN<br><b>Baltimore</b>   |   |
| 17. INMATE ADDRESS<br><b>Mrs. Herlinda C. Yutzy 21207</b>   |  | 17b. CITY OR TOWN<br><b>Baltimore</b>   |   | 17c. STATE<br><b>Maryland</b>   |                            |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute cardiovascular collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arterio-sclerotic disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs</u>   |  |   |   |   |                            |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 yrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><u>Asthma</u>  |  |   |   |   |                            |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-30-70</u> 19 <u>70</u> to <u>7-4-84</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>June 29, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |                            |   |   |
| 22b. SIGNATURE<br><u>Morton J. Ellin</u>  |  |   |   | DEGREE<br><b>M.D.</b>   |                            | 22c. DATE SIGNED<br><b>7-6-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Morton J. Ellin</b>   |  |   |   | 22e. ADDRESS<br><b>5310 Old Court Road 21133</b>  |                            |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-7-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eldersburg Carroll Maryland</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, Maryland 21133</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 6 1984</b>  |                            |   |   |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>J. L. Davidson</u>   |                            |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 0 9 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |   |  |   |  |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. Benjamin Gottlieb</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 26 1984</b>                             |   |  | 2b. HOUR<br><b>1310 M</b>  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 29 1922</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>62</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Garage</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Door Company</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Milford</b>                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3629 Florida Rd. 21207</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jacob Gottlieb</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Levy Gottlieb</b>             |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>214-16-3571</b>   |  |   | 17. INMATE ADDRESS<br><b>Mrs. Mary F. Gottlieb 3629 Florida Rd. Baltimore Maryland</b> |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SHOCK (HYPOVOLEMIC)</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>LONGESTIVE HEART FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>MITRAL REGURGITATION</b>   |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Hafeez A Syed</b>   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   | 22c. DATE SIGNED<br><b>7/26/84</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFAEEZ A SYED M.D.</b>  |  |   | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN HOSPITAL</b>                                   |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>7-30-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eldersburg Carroll Maryland</b>                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>  |  |   |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>JUL 30 1984</b>                   |  |   |  |   |  |
| 26. ADDRESS<br><b>8728 Liberty Road Randallstown, Maryland 21133</b>   |  |   |  |   | 27. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>                 |  |   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 0 0

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN R. GRAHAM SR.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 11, 1984</b>                                     |  | 2b. HOUR<br>P<br><b>11:55</b><br>M   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 22 1927</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2410 WHITT RD. 21087</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK DRIVER</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GULF OIL CO.</b>   |
| 13a. STATE<br><b>MD.</b>  | 13b. COUNTY<br><b>BALTO.</b>   | 13c. CITY OR TOWN<br><b>KINGSVILLE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2410 WHITT RD. 21087</b>                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CARLYE GRAHAM</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IRENE</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-22-9067</b>  | 17. INFORMANT<br>ADDRESS<br><b>EILEEN GRAHAM (WIFE) SAME ADDRESS</b>                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Small cell lung cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22. I certify that (it) this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (it) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (it) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>James M. Jones M.D.</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>7/13/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>UNIVERSITY HOSPITAL</b>   |  | 22e. ADDRESS<br><b>22 S. Greene St., Balto., Md. 21201</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>7/14/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BELAIR MEM. GARDENS</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SCHIMUNEK FUNERAL HOME, INC.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 18 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                          |  |
|   |  | 25c. ADDRESS<br><b>9705 BELAIR RD., BALTO. MD. 21213</b>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 allows only injury, or other traumatic event, the medical examiner must be notified of cause.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |  |   |   |
|---|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GERTRUDE GUBERMAN</b>  |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>27</b> YEAR <b>84</b>   |  | 2b. HOUR<br><b>4 15<sup>P</sup></b>   |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>15</b> YEAR <b>02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS  |   |
| 7a. BIRTHPLACE<br>(TYPE OR PRINT) <b>POLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD                                 |   |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>James H. Carver Center for the Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>             |
| 13a. STATE<br><b>MARYLAND</b>   |   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST <b>ISAAC</b> MIDDLE <b>ISRAEL</b> LAST <b>SHENKER</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>FANNIE</b> MIDDLE <b>FINKELSTEIN</b> LAST <b>FINKELSTEIN</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220-09-3011</b>   |  | 17. INFORMANT <b>MR. RONALD GUBERMAN</b><br><b>11303 SOUTH SHORE DR., RESTON, VA 22090</b>      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 day</b> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>5 years</b>   |   |  |  |   | <b>1 day</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>organic brain disease</b>   |   |  |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Dec 26</b> , 19 <b>80</b> , to <b>July 27</b> , 19 <b>84</b> , that (I) <del>last</del> lost saw the deceased alive on <b>July 27</b> , 19 <b>84</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> saw the body after death. |   |  |  |   |   |
| 22b. SIGNATURE<br><b>Manuel Levin</b>   |   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7/27/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANUEL LEVIN, M.D.</b>  |   | 22e. ADDRESS<br><b>6101 PARK HILLS AVE BALTO MD 21215</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |   | 23b. DATE<br><b>7-29-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH JACOB ANSHE VESHEAR CONG.</b>                     |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>   |   | 23e. DATE REC'D. BY REGISTRAR <b>AUG 1 1984</b>  |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |

BP

STATE OF NEW YORK  
IN SENATE  
January 10, 1907.

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 10, 1907.  
ALBANY:  
J. B. LIPPINCOTT & CO.,  
PRINTERS.  
1907.

B

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418102

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>DORIS FLORENCE GUNTER   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 9 84                                       |  | 2b. HOUR<br>2:55 P <sup>M</sup>  |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8- 27- 15   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br>DUNDALK   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERIDIAN NSG.CTR.HERITAGE |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>EXEC. SECRETARY |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>STEEL STRAPPING   |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>DUNDALK   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN L. FITZELL  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LILY GRAY                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-12-7070  |   | 17. INFORMANT<br>ADDRESS<br>SHANNON L. BRUNSON 4940 WINDHAVEN COURT<br>DUNWOODY, GEORGIA 30338 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic ovarian carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Pneumonia</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>Atherosclerotic Cardiovascular Disease</u>  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 19, 1984</u> , to <u>July 9, 1984</u> , that (I) (we) lost saw the deceased alive on <u>July 9, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Cheng Chung Lin</u>   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   | 22c. DATE SIGNED<br><u>July 9, 1984</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHENG CHUNG LIN   |  | 22e. ADDRESS<br>6801 Belair Rd Baltimore Md<br>21206  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  | 23b. DATE<br>7/10/1984  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT CREMATORY                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MARYLAND  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WALTER BROOKS BRADLEY, INC.  |  |   | ADDRESS<br>DUNDALK, MD. 21222   |  | 25a. DATE REG'D. BY REGISTRAR<br>JUL 12 1984   |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Johanna Davidson-Randall</u>                       |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418103

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                            |  |
|---|--|---|--|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Roy Ray Haley</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 7 84</b> |   | 2b. HOUR<br><b>7:40 PM</b> |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 24, 1908</b>   |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co., MD.</b>   |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Construction Work</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |                            |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Carroll</b>   |  | 13c. CITY OR TOWN<br><b>Sykesville</b>  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Henry Haley</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ninnie B. Mills</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>214-20-5802</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Glen Burnie, Md.<br/>1 Glenwood Dr.</b>  |  |   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gangrene Left foot</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple diabetes</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pneumonia, PVD</b> |  |   |  |   |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/7/84</b> 19 <b>did at</b> 19 <b>7:40 PM</b> that (I) (we) lost saw the deceased alive on <b>7/7/84</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                            |  |
| 22b. SIGNATURE<br><b>Dr. Singh</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>7/7/84</b>   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. SINGH</b>   |  | 22e. ADDRESS<br><b>BCGH, Baltimore</b>  |  |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>7-10-1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial</b>   |                            |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Carroll, Md.</b>  |  | 23e. DATE REC'D. BY REGISTRAR   |  | 23f. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Charles W. Burrier, Jr., Sykesville, Md.</b>   |  |   |  |   |                            |  |

BP

Charles E. Hartley, Jr., Sykesville, Md.  
 7-10-41 Lake View Memorial  
 Carroll, Md.

Louis Henry Harry  
 210-30-283 James W. Phillips, Glenwood Co.  
 1111-

Maryland Carroll Sykesville x 3712 1st Ave. (21784)

Philadelphia Baltimore County Hospital Construction Corp

Maryland U.S.A. Baltimore Co.

also White May 24, 1900 78 13

Haley

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 0 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>IRVIN L. HALL  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 15 84                |   | 2b. HOUR<br>6 15 P M  |
| 3. SEX<br>Male  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 6 08   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County x MD                                   |   |
| 10. CITY OR TOWN OF DEATH<br>Towson   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>523 Chateau Ave. 21212  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Perry Sullivan  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sadie Hall   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br>Daisy Hall 523 Chateau Avenue                                       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CVA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Sepsis Disruption of Anastomosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CA of the Cecum   |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10.  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br>Celando Romero  |  | DEGREE  |  | 22c. DATE SIGNED<br>7/15/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. CHARLES KIM  |  | 22e. ADDRESS<br>St. Joseph Hosp.  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>7/21/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Church Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Magothy MD  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 17 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Wm. C. March  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

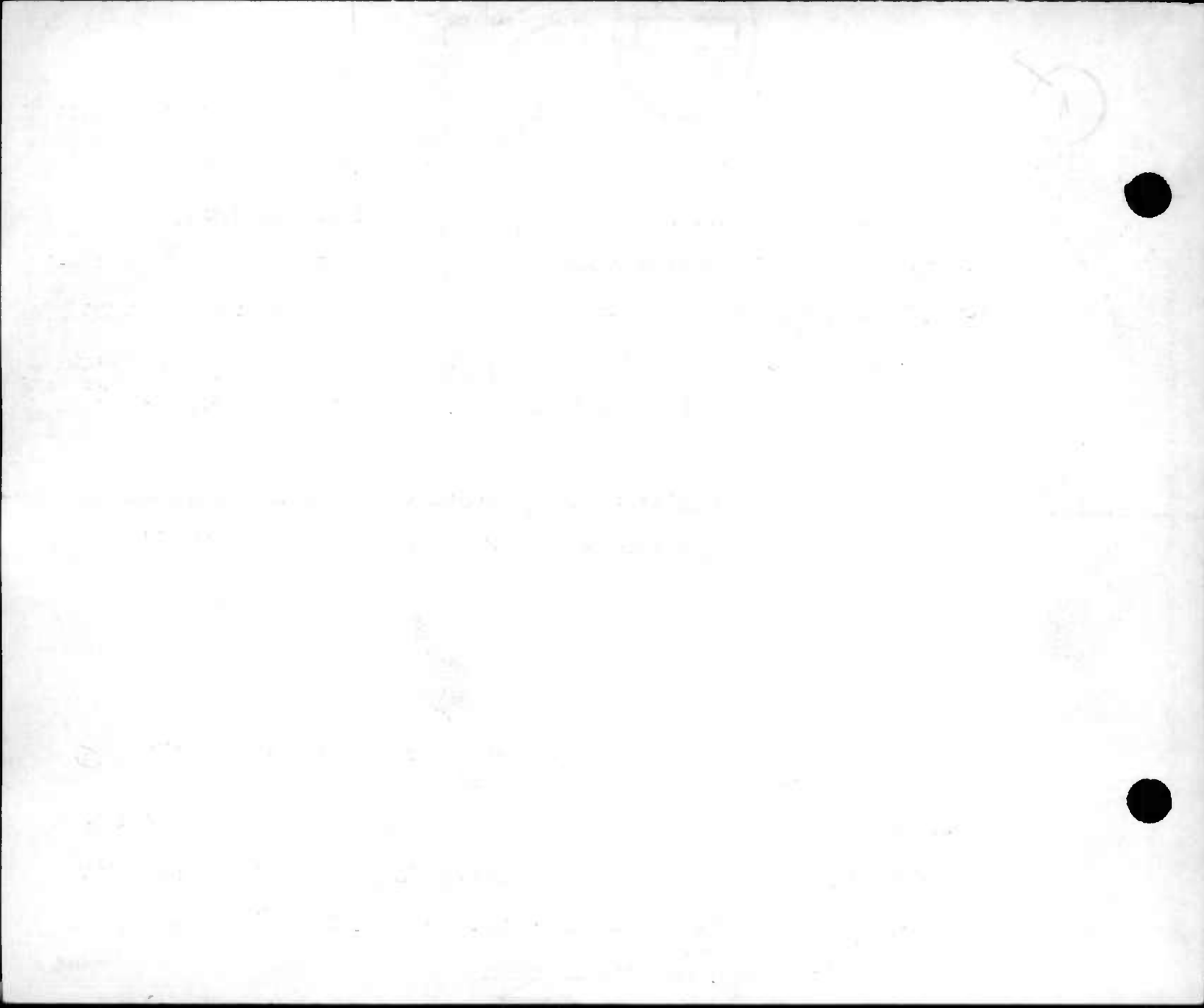
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |                                    |  |                                   |  |
|--|---|---|---|--|------------------------------------|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH   |  |                                    | 2b. HOUR   |                                   |  |
| FIRST MIDDLE LAST<br>Willard William Hall  |   |   | MONTH DAY YEAR<br>7 1 1984  |  |                                    | 8:30 A.M.  |                                   |  |
| 3 SEX  | 4 RACE  | 5. DATE OF BIRTH  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |                                    | IF UNDER 1 YEAR  |                                   |  |
| Male   | White   | MONTH DAY YEAR<br>1 14 1913   | 71 YRS  |  |                                    | IF UNDER 24 HRS  |                                   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                                    |  |                                   |  |
| Pennsylvania   | U.S.A.  |   | Baltimore County MD   |  |                                    |  |                                   |  |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |                                   |  |
| Dundalk  | 7727 Fairgreen Road   |   | Welder  |  |                                    | J & L Steel  |                                   |  |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  |  |                                    | 13e. STREET ADDRESS / ZIP CODE   |                                   |  |
| Pennsylvania   | Allegheny   | Pittsburgh  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                    | 28 Nansen Street 15207   |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                       |  |                                    |  |                                   |  |
| Orlando O. Hall  |   |   | Ida Butterbough   |  |                                    |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |   | 16b. SOCIAL SECURITY NO.  |  |                                    | 17. INFORMANT  |                                   |  |
| No   |   |   | 166-10-6228   |  |                                    | Betty L. Krakowiak   |                                   |  |
|  |   |   |   |  |                                    | ADDRESS: 7727 Fairgreen Road Balto. MD 21222                                   |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Lung Cancer<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic lung disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Smoking and asbestos exposure |   |   |   |  |                                    |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |  |                                    |  |                                   |  |
| 19a. DATE OF OPERATION   |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |   |   |   |  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |  |
|  |   |   |   |  |                                    |  |                                   |  |
| 22a. I certify that (1) this hospital attended the deceased from March 19 83 to June 29 84, that (1) (we) last saw the deceased alive on June 25 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) sew the body after death.   |   |   |   |  |                                    |  |                                   |  |
| 22b. SIGNATURE   |   |   | DEGREE  |  |                                    | 22c. DATE SIGNED   |                                   |  |
| Susan Denman   |   |   | M.D.  |  |                                    | 7/2/84   |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   | 22e. ADDRESS  |  |                                    |  |                                   |  |
| Susan Denman   |   |   | 5200 Eastern Ave Balt Md  |  |                                    |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION                     |  |
| Burial   |   |   | 7/5/84  |  | Jefferson Mem. Park                |  | Jefferson Township, Allegheny, PA |  |
| 24. FUNERAL DIRECTOR   |   |   | 25a. DATE REC'D. BY REGISTRAR                                       |  |                                    | 25b. REGISTRAR'S SIGNATURE   |                                   |  |
| NAME Duda-Ruck, Inc.<br>7922 Wise Avenue, Dundalk, MD 21222  |   |   | JUL 2 1984  |  |                                    | John Davidson-Randall  |                                   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH IN 100-000000 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |  |                  |  |  |  |   |  |   |  |
|--|--|------------------|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Dawn V. Hamilton   |  |                  |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>7 25 1984  |  |   |  | 2c. HOUR<br>M<br>5:15 P   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Cauc. |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 16, 1975                  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>9 YRS.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>7 25 1984   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.  |  |                  |  | 10. CITY OR TOWN OF DEATH<br>Rossville                               |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>woods off Rossville Blvd.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student   |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>--                              |  |   |  |   |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br>8749 Fontana La, 21236  |  |                  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas P. Hamilton         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Toni C. Tranguccio   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>--        |  | 17. INFORMANT<br>ADDRESS<br>unknown   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Blunt trauma to head and strangulation<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |                  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                    |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 7 25 1984  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Subject beaten and strangled |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>woods |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>off Rossville Blvd, Rossville, Balto., MD.               |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>7/28/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>SCHIMUNEK FUNERAL HOME, 3331 Brehms La, 21214  |  |                  |  | 25a. DATE REC'D. BY REGISTRAR<br>7/30/1984                           |  | 25b. REGISTRAR'S SIGNATURE<br>F. Davidson   |  |   |  |

EXAMINER'S NAME  
(TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS

111 Penn St. Balto., MD.

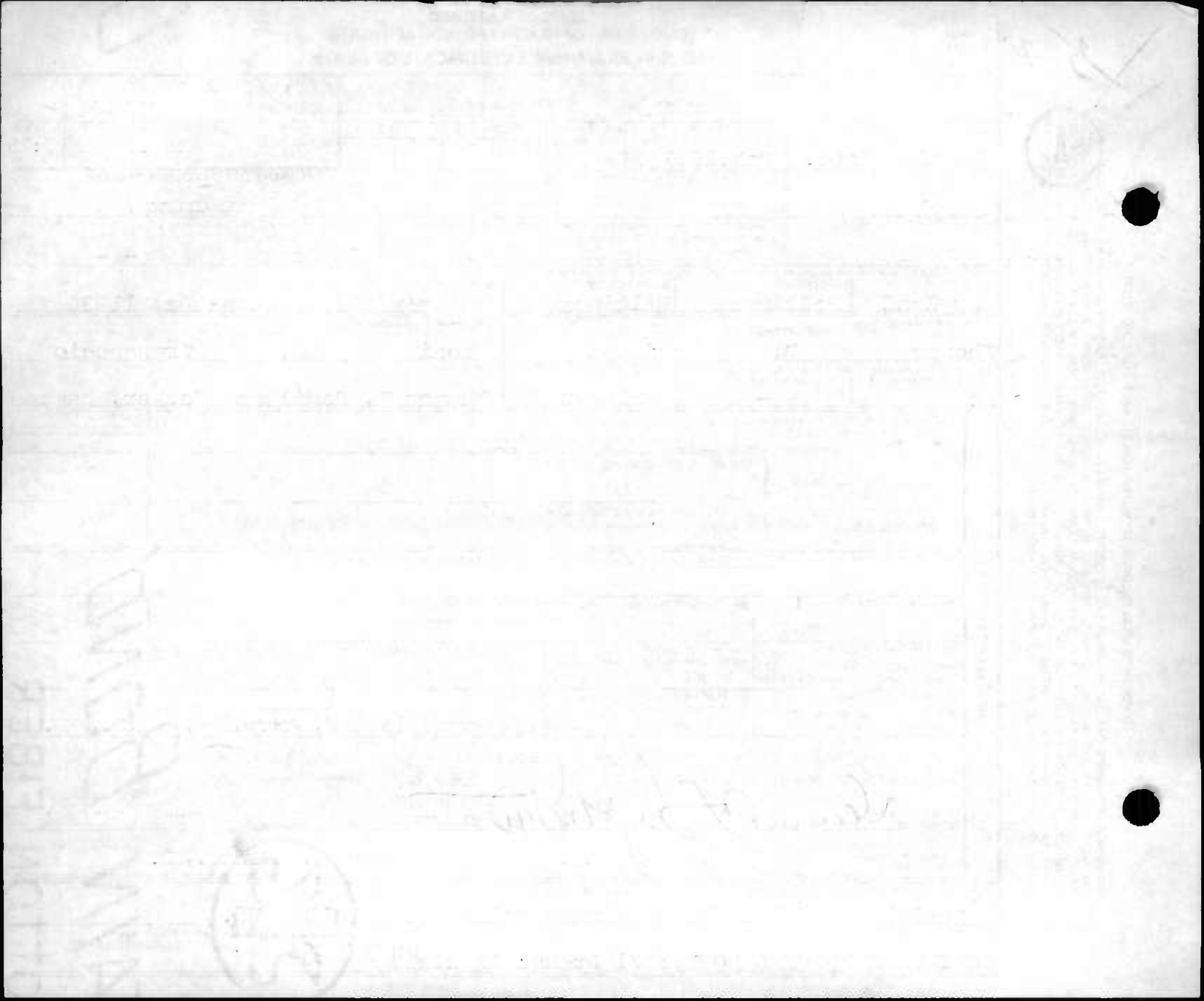
ACTUAL  
SIGNATURE

*Dennis F. Smyth, M.D.*

TITLE (SPECIFY)

Assistant MEDICAL EXAMINER

DATE SIGNED 7/26/84





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 0 7

REG. NO.

|   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Bertha ELIZABETH Hamman</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 22 84</b> |  |  | 2b. HOUR<br><b>12:30 AM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 29, 1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, County MD</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT AGING HOME OR NURSING HOME)<br><b>Jennings Memorial Home 1660 S. Caton Ave. 21229</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August Hammann</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Tobin</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-070309</b>   |  | 17. INFORMANT ADDRESS<br><b>Sr. Mary Charles 6410 E. Pratt St 21224</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>deletory of chronic brain syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. Certify that (I) (this hospital) attended the deceased from <b>6/11/80</b> , 19____, to <b>7-22</b> , 19 <b>84</b> , that (we) last saw the deceased alive on <b>7-22</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Lawrence Gallagher</b>   |  |  |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>7/23/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Gallagher</b>  |  |  |   | 22e. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-25-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME 6500 YORK ROAD</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 24 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8418108   |  |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 20. DATE OF DEATH MONTH DAY YEAR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ANNIE ELLEN HARPER  |  |  |  | 20. DATE OF DEATH MONTH DAY YEAR<br>July 28 1984                                     |  |
| 2. SEX F  |  | 4. RACE WHITE  |  | 20. HOUR 1 P.M.  |  |
| 3. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>JUN 04 1991   |  | 21. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. IF UNDER 1 YEAR MONTHS DAYS   |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>OLD COURT NURSING CENTER |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                         |  |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY HOWARD 13c. CITY OR TOWN ELICOTT CITY   |  | 14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 15. STREET ADDRESS / ZIP CODE<br>4802 HALE HAVEN DR. 21043                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN TYLER GRAY  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNIE REBECCA WEBB   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  | 16. SOCIAL SECURITY NO. 216-07-3181  |  | 17. INFORMANT ADDRESS<br>Beverly Duckstad 4802 Hale Haven Dr. ELICOTT CITY, MD 21043 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CA Colon<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-28-84 to 7-28-84, that (I) (we) lost saw the deceased give an <input checked="" type="checkbox"/> (we) (did not) view the body after death.  |  |  |  |  |  |
| 22b. SIGNATURE<br>MB T. ARMON   |  | DEGREE   |  | 22c. DATE SIGNED<br>7-30-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br>5400 OLD COURT RD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>8-1-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem.                                |  |
| 24. FUNERAL DIRECTOR NAME<br>SLACK FUNERAL HOME   |  | ADDRESS<br>602 268 ELICOTT CITY MD 21043   |  | 25a. DATE RECD. BY<br>AUG 1 1984   |  |
| 25b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 25c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 0 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MAYNARD S. HARSH SR.   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>JULY 7 1984   |   | 2b. HOUR<br>M  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APRIL 25 1920   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. VA.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. COUNTY MD.                                       |   |  |
| 10. CITY OR TOWN OF DEATH<br>MIDDLE RIVER   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>14 TAXI WAY |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD  | 13b. COUNTY<br>BALTO.  | 13c. CITY OR TOWN<br>MIDDLE RIVER   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>14 TAXI WAY 21220  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>PETER C. HARSH  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RACHEL J. POWELL   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>232-22-871 WWII  |   | 17. INFORMANT<br>ADDRESS<br>VICTORIA HARSH 14 TAXI WAY  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cordiac Stand Still<br>DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE  |  | DEGREE  |   | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Saul   |  | 22e. ADDRESS  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>JULY 10, 1984  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLLY HILL MEMORIAL                                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MIDDLE RIVER BALTO. MD   |
| 24. FUNERAL DIRECTOR<br>NAME<br>CONNELLY FUNERAL HOME   |  |   | ADDRESS<br>300 MAICE AVE  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 11 1984   |
|   |  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |   |  |

MEDICAL CERTIFICATION

BP \_\_\_\_\_

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 4 1 8 1 1 0   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST <u>Victoria</u> MIDDLE <u>Alexandria</u> LAST <u>Harsh</u><br><u>VICTORIA HARSH</u>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>7</u> <u>30</u> <u>84</u>  |  |   |  |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>Cauc.</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>12</u> <u>10</u> <u>24</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><u>59</u>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><u>Morgantown, W. Va.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore County</u> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Towson</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Stella Menn Hospice</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Secretary</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Aircraft Mfg.</u>   |  |
| 13a. STATE<br><u>Maryland</u>  |  | 13b. COUNTY<br><u>Baltimore</u>  |  | 13c. CITY OR TOWN<br><u>Middle River</u>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>Sam</u> <u>Shaluta</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Mary</u> <u>Povish</u>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN) <u>No</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>235 32 6372</u>   |  | 17. INFORMANT ADDRESS<br><u>Maynard S. Harsh, Jr. Son 802 Sue Grove Rd. Balto., Md. 21221</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypercalcemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Lung cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-25-84</u> to <u>7-30-84</u> that (I) (we) last saw the deceased alive on <u>7-30-84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did/did not view the body after death.)  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>DR Faulkner MD</u>  |  |  |  | DEGREE  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DR Faulkner MD</u>   |  |  |  | 22e. ADDRESS<br><u>Stella Menn Hospice 2300 Dulany Valley Rd 21204</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><u>Burial</u>   |  | 23b. DATE<br><u>8/1/84</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Holly Hill Memorial Gardens</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Baltimore Co., Md.</u>  |  |
| 24. FUNERAL HOME<br><u>Prudzenski Funeral Home PA 1407 Old Eastern Ave</u>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JUL 31 1984</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>J</u>  |  |

MEDICAL CERTIFICATION







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 1 1

FOR  
1- STATE  
REGISTRAR

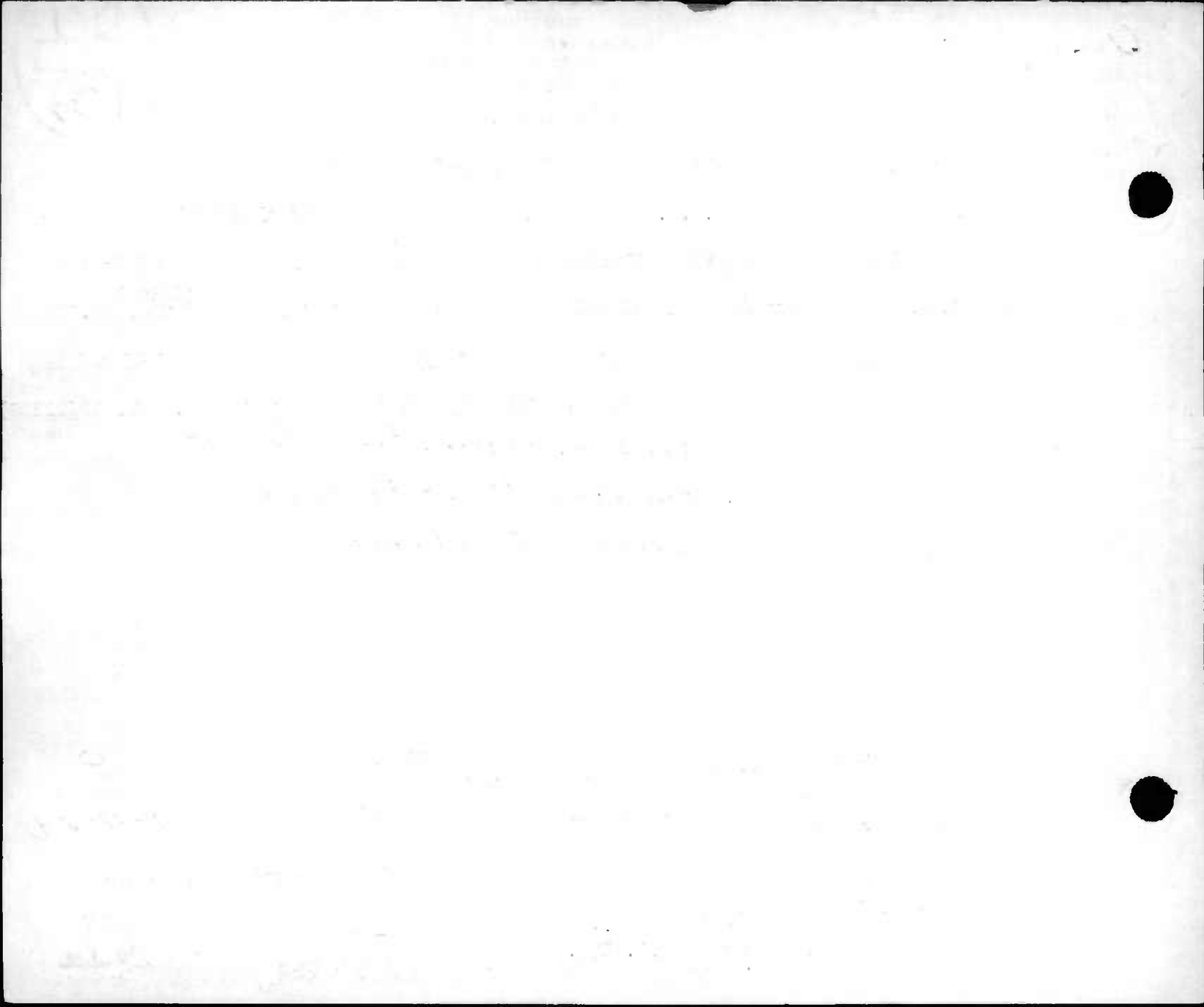
REG. NO.

|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELLEN</b> <b>HAYNAL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 11 84</b>                 |   |  | 2b. HOUR<br><b>9:20 PM</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 27, 1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>AUSTRIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PIKESVILLE NURSING HOME</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOMEMAKER</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  | 13e. STREET ADDRESS / ZIP CODE (21208)<br><b>12 STONEHENGE CIRCLE, APT. 12</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>IGNAZ WEIHS</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH UNKNOWN</b> |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>120-20-3106</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>RALPH HAYNAL 12 STONEHENGE CIR., APT. 12 (21208)</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe Cachexia</b> |  |   |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>7-12</b> 19 <b>80</b> , to <b>7-11</b> 19 <b>84</b> , that (2) (we) last saw the deceased alive on <b>7-11</b> 19 <b>84</b> and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) (did) not view the body after death.  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Edward Sherman</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |   |   |  | 22c. DATE SIGNED<br><b>7-12-84</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Edward Sherman</b>   |  |   |   | 22e. ADDRESS<br><b>8726 Liberty Rd Plaza Mall</b>   |  |  |  |  |  |
| 23a. BURIAL - CREMATION, REMOVAL<br>(SPECIFY) <b>REMOVAL-BURIAL</b>  |  | 23b. DATE<br><b>7/13/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. MORIAH CEM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>RIDGEFIELD NEW JERSEY</b>                                   |  |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1984</b> 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 1.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |   |                  |   |  |   |  | REG. NO. 4 1 8 1 1 2 |  |
|--|-------------------------|--|---|---|------------------|---|--|---|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE B. HEBLER</b>  |                         |  |   |   |                  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>7 22 19 84</b> |  | 2b. HOUR <b>M</b>   |  |                      |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6-14-1906</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>78</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>7 22 19 84</b>  |  | 2d. HOUR <b>10:10 a.m.</b>  |  |                      |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>   |                         | 7c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |   |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>White Marsh</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Philadelphia &amp; Joppa Rds.</b> |   |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painter-Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Johns Hopkins University</b>                |  |                      |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET ADDRESS<br><b>5402 Cedella Ave. 21206</b>                               |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Hebler</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Caroline Beckman</b>  |                  |   |  |   |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>212-07-2690</b>   |   | 17. INFORMANT ADDRESS<br><b>Mrs. Mildred M. Hebler-5402 Cedella Ave. 21206</b>  |                  |   |  |   |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |   |   |                  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |  |   |   |                  |   |  |   |  |                      |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                  |   |  |   |  |                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                  |   |  |   |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |   |   |                  |   |  |   |  |                      |  |
| ACTUAL SIGNATURE<br>  |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |   |   |                  |   |  | DATE SIGNED <b>7-23-84</b>  |  |                      |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |                         | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |   |   |                  |   |  |   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>7-25-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>   |                  | 23d. LOCATION<br>CITY OR TOWN STATE<br><b>Balto. Md. -21206</b>   |  |   |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>  |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 24 1984</b>   |                  | 25b. REGISTRAR'S SIGNATURE<br>             |  |   |  |                      |  |

Balto. Md. - 21305

John W. H. H. H. H. H.

7-57-84

Barrel

John C. Miller Inc. - 21305

21305

No

213-07-3590

Mr. Richard A. Hepler - 7405 Celala Ave.

Richard Hepler

(unofficial)

Baltimore

x

7405 Celala Ave.

21305

Painter - retired  
University

U.S.A.

Balto. Md.

6-14-1902

78

x

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAPERS 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. HESTON STREET,  
BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP\_\_\_\_\_

DHMH - 17

(VR A15 ME (5))

20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                  |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH              |  |  |  |  |  |  |  |  |  | REG. NO.                             |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------------------|--|--|--|--|--|--|--|--|--|-------------------------------|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH                                  |  |  |  |  |  |  |  |  |  | 2b. DATE OF ESTIMATED DEATH                          |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD             |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Kate Heimann  |  |  |  |  |  |  |  |  |  | 7 31 1984  |  |  |  |  |  |  |  |  |  | 7 31 1984  |  |  |  |  |  |  |  |  |  | 5 35 P.M.                            |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH                                     |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS)                    |  |  |  |  |  |  |  |  |  | 7. IF UNDER 1 YR.             |  |  |  |  |  |  |  |  |  | 8. IF UNDER 24 HRS. |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| FEMALE  |  |  |  |  |  |  |  |  |  | WHITE  |  |  |  |  |  |  |  |  |  | AUG. 23, 1897  |  |  |  |  |  |  |  |  |  | 86 YRS.                              |  |  |  |  |  |  |  |  |  | MONTHS                        |  |  |  |  |  |  |  |  |  | DAYS                |  |  |  |  |  |  |  |  |  | HOURS |  |  |  |  |  |  |  |  |  | MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  |  |  |  |  |  |  |  |  | 8. MARRIED   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| GERMANY   |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  | WIDOWED  |  |  |  |  |  |  |  |  |  | Baltimore County                     |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION                                |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| BALTIMORE   |  |  |  |  |  |  |  |  |  | 819 JUDY LANE  |  |  |  |  |  |  |  |  |  | HOUSEWIFE  |  |  |  |  |  |  |  |  |  | AT HOME                              |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 13a. STATE  |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN                                    |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?             |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS           |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| MARYLAND  |  |  |  |  |  |  |  |  |  | BALTO.   |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |  |  |  |  |  |  |  |  | YES                                  |  |  |  |  |  |  |  |  |  | NO                            |  |  |  |  |  |  |  |  |  | 819 JUDY LA. #21208 |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                 |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?         |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.             |  |  |  |  |  |  |  |  |  | 17. INFORMANT                 |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| MAX   |  |  |  |  |  |  |  |  |  | ROSA   |  |  |  |  |  |  |  |  |  | NO   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  | MRS. ERIKA LISBERGER          |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | SCHILDHAUS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  | 819 JUDY LA. BALTO., MD 21208 |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  | Immediate  |  |  |  |  |  |  |  |  |  | YES  |  |  |  |  |  |  |  |  |  | NO                                   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Asphyxiation by Hanging   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| (b)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES  |  |  |  |  |  |  |  |  |  | NO                                   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY                                      |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED                             |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | HOUR A.M. MONTH DAY YEAR                                 |  |  |  |  |  |  |  |  |  | (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY                                     |  |  |  |  |  |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | STREET, FACTORY, FARM, ETC.)                             |  |  |  |  |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE                     |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy   |  |  |  |  |  |  |  |  |  | Inspection   |  |  |  |  |  |  |  |  |  | Inquiry  |  |  |  |  |  |  |  |  |  | and in my opinion                    |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| death resulted from: Natural causes   |  |  |  |  |  |  |  |  |  | Accident   |  |  |  |  |  |  |  |  |  | Suicide  |  |  |  |  |  |  |  |  |  | Homicide                             |  |  |  |  |  |  |  |  |  | Undetermined manner           |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |  |  |  |  |  |  |  |  | M.D.   |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER                                     |  |  |  |  |  |  |  |  |  | DATE SIGNED                          |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Stanley Z. Felsenberg M.D.  |  |  |  |  |  |  |  |  |  | Deputy   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 8/1/84                               |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Stanley Z. Felsenberg M.D.  |  |  |  |  |  |  |  |  |  | 11 E. Chase Street 21202                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY                   |  |  |  |  |  |  |  |  |  | 23d. LOCATION                        |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| BURIAL  |  |  |  |  |  |  |  |  |  | 8/1/84   |  |  |  |  |  |  |  |  |  | CHEVRA AHAVAS CHESED                                 |  |  |  |  |  |  |  |  |  | RANDALLSTOWN BALTO. MD               |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                            |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE                           |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| SOL LEVINSON & BROS., INC.  |  |  |  |  |  |  |  |  |  | AUG 7 1984   |  |  |  |  |  |  |  |  |  | Lelia Davidson-Randall                               |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |

STATE OF NEW YORK  
IN SENATE  
January 12, 1904  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1903  
ALBANY:  
J. B. LEECH, STATE PRINTER  
1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothea Ann Heimert  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 2, 1984 |   |  | 2b. HOUR<br>3:52 <sup>P</sup> <sub>M</sub>  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 8, 1905   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaking  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |  |   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>531 Stevenson Lane #21204  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry W. Blondell  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jenny Weininger  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No -----   |  |   |   | 16b. SOCIAL SECURITY NO.<br>219-44-5343   |  | 17. INFORMANT<br>ADDRESS<br>Towson<br>Dorothy M. Heimert, 11 Sonachan Ct. 21204                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized Arterio-</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>sclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
|  |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Cerebral sclerosis, Senility</u>   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>4/19</u> , 19 <u>84</u> , to <u>7/2</u> , 19 <u>84</u> , that (we) last saw the deceased alive on <u>5/31</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or we) (did not) view the body after death.                                     |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Henri Koetter M.D.</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   |   |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henri Koetter, M. D.  |  |   |   | 22e. ADDRESS<br>7600 Osler Drive, Towson, Maryland 21204  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>July 5, 1984   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Martin D. Lawson   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 5 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

BP

1

March 5, 1962

March 5, 1962

USA

Baltimore County

Speaker, Baltimore County, Maryland

March 5, 1962

March 5, 1962

March 5, 1962

March 5, 1962

March 5, 1962

March 5, 1962

March 5, 1962

March 5, 1962



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

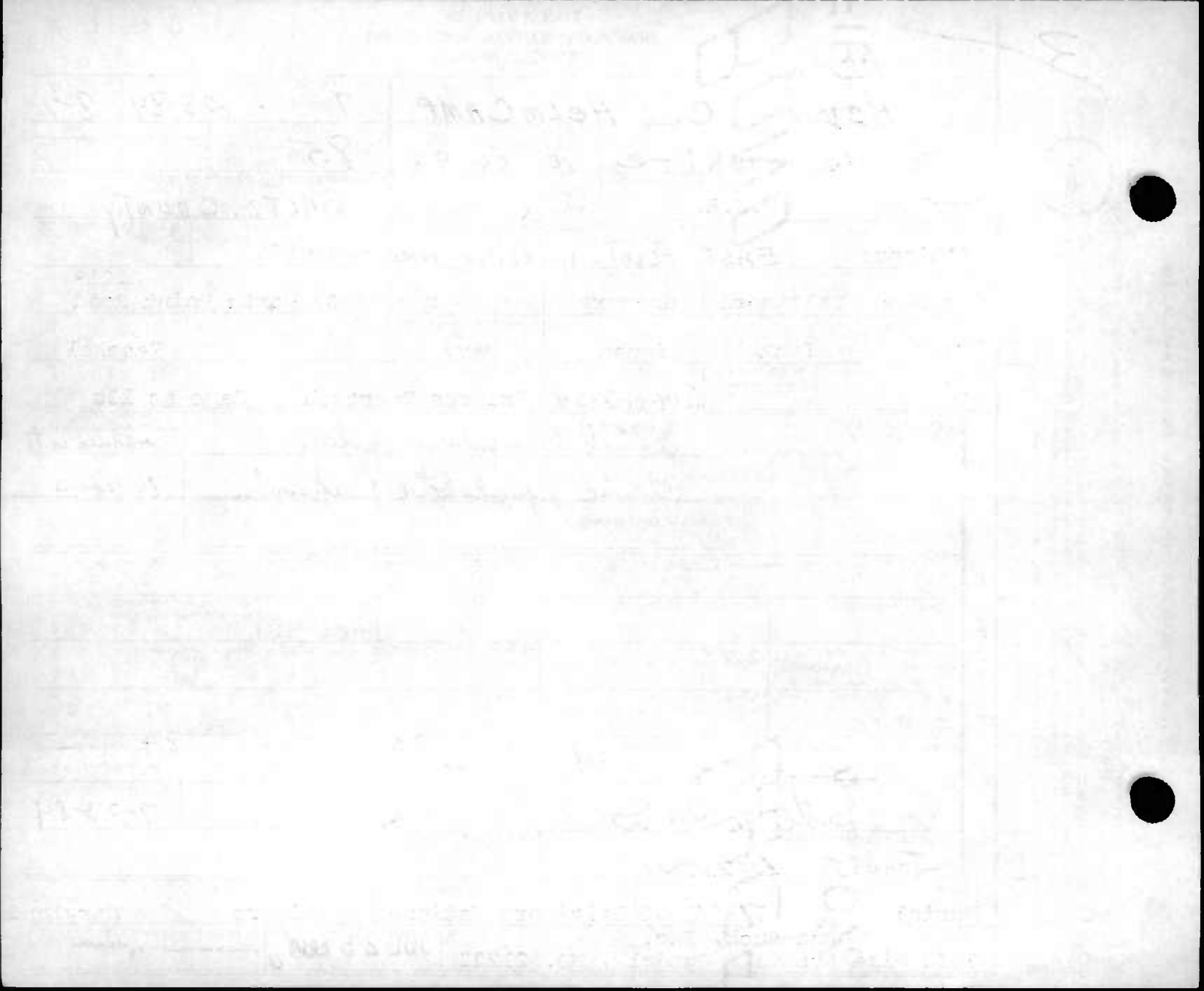
8 4 1 8 1 1 5

|   |  |   |  |
|---|--|---|--|
| FOR<br>STATE<br>REGISTRAR <i>Helen C</i>  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Helen C. HELMCAMP</i>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>7 - 23-84</i>   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 06 98</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>85</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTD. COUNTY</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>EAST POINT NURSING HOME</i> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   |  |
| 13c. CITY OR TOWN<br><i>Edgemere</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS / ZIP CODE<br><i>8607 North Point Road 21219</i>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>James I. Dignan</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Yaeckel</i>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>214-01-2834</i>  |  |
| 17. INFORMANT<br>ADDRESS<br><i>Frances Foertsch Same as 13e</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <i>Central Respiratory Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Lymphocytic Leukemia</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>10 years</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Immediate</i>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>10</i>  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>10-06</i> , 19 <i>83</i> , to <i>7-23</i> , 19 <i>84</i> , that (I) (we) lost<br>saw the deceased expire on <i>7-23</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) examined and viewed the body after death.                            |  |   |  |
| 22b. SIGNATURE<br><i>John Littleton MD</i>  |  | 22c. DATE SIGNED<br><i>7-23-84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>John Littleton</i>  |  | 22e. ADDRESS<br><i>Baltimore</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>7/26/1984</i>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore National</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Duda-Ruck, Inc.<br/>7922 Wise Avenue Dundalk, MD. 21222</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 25 1984</i>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



[illegible]

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| FOR STATE REGISTRAR   |  |                  |  |   |  |  |  |   |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | REG. NO.            |  |
|---|--|------------------|--|---|--|--|--|---|--|---|--|---|--|--|--|--|--|--|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>HOWARD W. HELMRICH  |  |                  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED<br>7-26-84  |  |   |  |  |  |  |  |  |  | 2b. HOUR<br>8:05 PM |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>Jan. 30, 1909   |  | 6. AGE (IN YEARS)<br>75 YRS.                             |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>7-26-84                         |  |  |  |  |  |  |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto, Md.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD |  |  |  |  |  |  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>3314 Carroll Avenue |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Farmer   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |  |  |  |  |  |  |                     |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Owings Mills  |  |                  |  |   |  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 3314 Carroll Ave. 21117 |  |   |  |  |  |  |  |  |  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William F. Helmrich   |  |                  |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie Hawkins   |  |   |  |  |  |  |  |  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>218-01-1268   |  |  |  | 17. INFORMANT ADDRESS<br>Mrs. Linda D. Pond Randallstown, Md.   |  |   |  |   |  |  |  |  |  |  |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gunshot wound to head<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |  |   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |  |  |                     |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                               |  |  |  |   |  |   |  |   |  | 20. AUTOPSY?<br>(HEAD ONLY)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |                     |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>8:05 PM 7-26-84  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>self/inflicted   |  |   |  |   |  |  |  |  |  |  |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home             |  |  |  | 21f. LOCATION<br>3314 Carroll Ave. Owings Mills, Maryland   |  |   |  |   |  |  |  |  |  |  |  |                     |  |
| 22a. I certify that I took charge of the remains described (HEAD ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |  |  |                     |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.   |  |                  |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER<br>111 Penn Street                |  |  |  |   |  |   |  |   |  | DATE SIGNED<br>7-27-84   |  |  |  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>July 31, 84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreen Memorial |  |   |  | 23d. LOCATION<br>Finksburg, Md.   |  |   |  |  |  |  |  |  |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Eline Funeral Home Reisterstown, Md.  |  |                  |  |   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 30 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall              |  |  |  |  |  |  |  |                     |  |



Handwritten text, possibly a list or notes, located in the center-right area of the page. The text is faint and difficult to read, but appears to be organized in a vertical column.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 4 1 8 1 1 7   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>EVA I. HEPBURN</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>7 25 84</b>  |  | 2b. HOUR<br><b>12 35 P</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 18 97</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>86</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Nursing Home</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br><b>Maryland Anne Arundel</b>   |  | 13c. CITY OR TOWN<br><b>Pasadena</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>7748 Edgewood Avenue 21122</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles Bradley</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Carrie Fontz</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-04-9914</b>  |  | 17. INFORMANT ADDRESS<br><b>Baltimore, Md. 21237</b><br><b>Mr. Robert E. Hepburn 8925 Philadelphia Rd.</b>                               |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |   |  |   |  |
| MEDICAL CERTIFICATION   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>4:16 P.M. 19 84</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> 19 <b>84</b> , to <b>7/25</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>7/25/84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Jeffrey A. Zlotnick MD</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>7/25/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeffrey A Zlotnick MD</b>   |  | 22e. ADDRESS<br><b>Franklin Sq Hosp. Balt MD</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/28/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Anne Arundel Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>McCully Funeral Home of Pasadena Mountain &amp; Tick Neck Rds. Pasadena, Md. 21122</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>AUG 19 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John B. Anderson</b>   |  |   |  |

WILFAM  
200% COLLECTION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 1 8

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                            |  |
|--|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CATHERINE E. HINCHLIFFE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 25, 1984</b> |   | 2b. HOUR<br><b>8:15 AM</b> |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 21, 1897</b>  |                            |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Timonium</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7 Tyburn Court</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.  |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>at home</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |   |                            |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Cavanaugh</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ellen Kelly</b>  |   |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213 74 6603</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>family records</b>   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MetaStatic Malignant Melanoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |  |  |   |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |   |   |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>July 25, 1984</b> to <b>July 25, 1984</b> that (1) (we) lost<br>saw the deceased alive on <b>July 25, 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.   |  |  |   |   |                            |  |
| 22b. SIGNATURE<br><b>Leon E. Kassel</b> DEGREE <b>(MD)</b>   |  |  |   | 22c. DATE SIGNED<br><b>7/26/84</b>  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Leon E. Kassel, M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>2435 W. Belvedere Avenue</b>   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>  |  | 23b. DATE<br><b>7/28/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>   |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. County, MD.</b>  |  | 23e. DATE REC'D. BY REGISTRAR  |   |   |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Evans Chapel of Memories 8800 Harford Rd.</b>   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John S. ...</b>  |                            |  |

MEDICAL CERTIFICATION

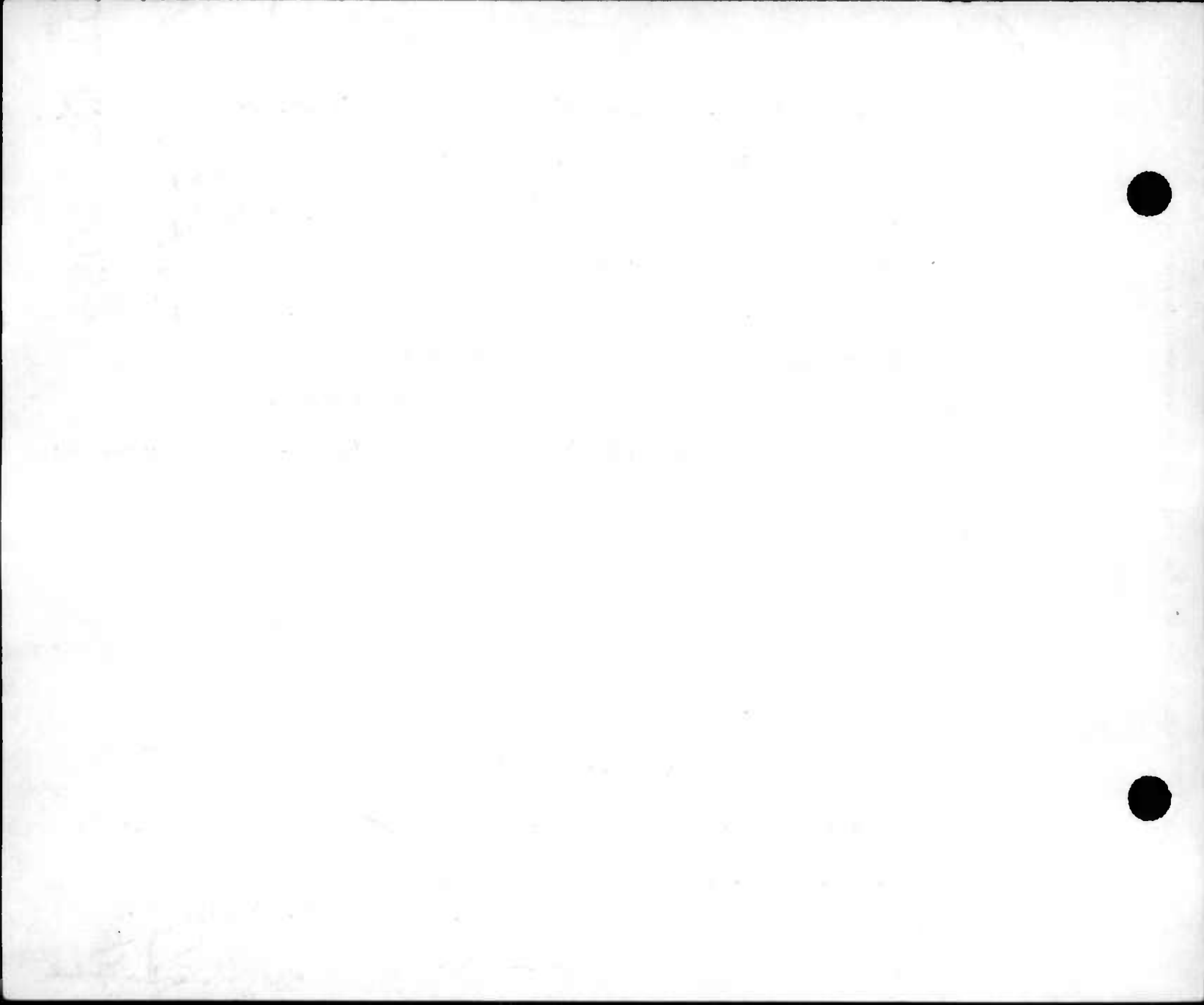
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

JUL 27 1984



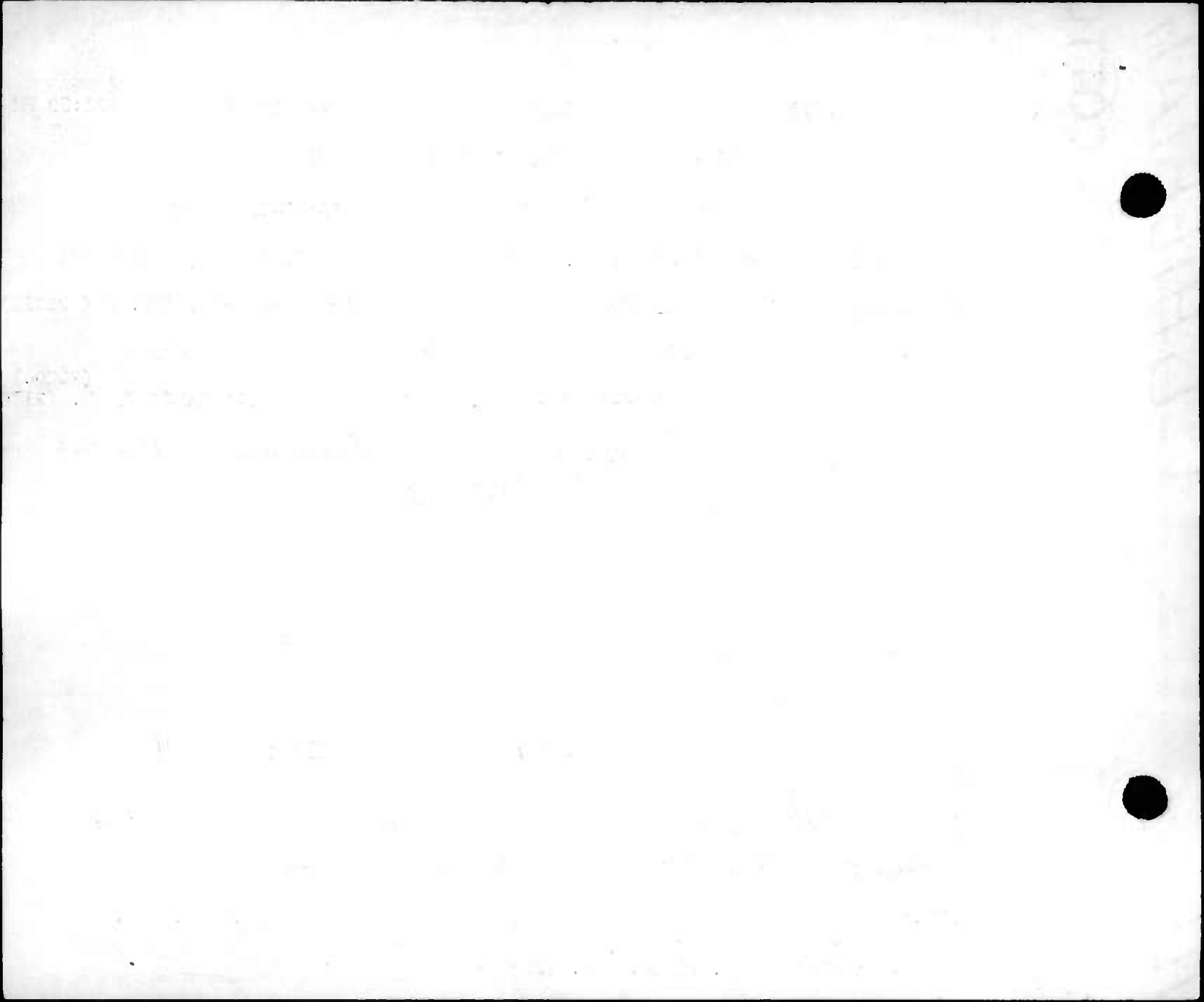


8 4 1 8 1 1 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |  |  |                                    |  |
|--|--|--|--|---|--|--|--|--|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>SONIA   |  | MIDDLE  |  | LAST<br>HIRRY  |  | 2a. DATE OF DEATH<br>JULY 12, 1984   |  | 2b. HOUR<br>11:59 PM               |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>NOV. 11, 1900   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 7b. IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |  |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br>PIKESVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4525 TAPSCOTT RD. (21208) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOMEMAKER   |  |                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>3628 FORDS LANE, APT. E (21215)  |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST<br>JULIUS<br>MIDDLE<br>LAST<br>BABKOFF  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>MARY<br>MIDDLE<br>LAST<br>COHEN   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  |  |  |                                    |  |
| 16b. SOCIAL SECURITY NO.<br>217-40-6955 A  |  | 17. INFORMANT<br>ADDRESS<br>MRS. GOLDIE SCHWARTZ 4525 TAPSCOTT RD. (21208)   |  |   |  |  |  |  |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ca of Colon with Metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |  |  |  |  |                                    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>2-7-79</u> , 19 <u>84</u> , to <u>5-13</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>5-13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |                                    |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  | DEGREE   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br>7/13/84  |  |                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BORIS KATZNER   |  | 22e. ADDRESS<br>131 SLADE AVE  |  |   |  |  |  |  |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>7/15/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SHAAREI ZION CEM  |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>ROSEDALE, BALTO., MD.  |  |  |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS.<br>6010 REISTERSTOWN RD. BALTO., MD. (21215)  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 17 1984   |  |  |  |                                    |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |   |  |  |  |  |  |                                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |                                 |   |  |
|--|--|--|--|---|---------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARIE THERESA HOCHREIN   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7-20-84 |   | 2b. HOUR<br>11:45P <sub>M</sub> |   |  |
| 3. SEX<br><del>XXXXX</del> Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 11, 1906   |                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, M County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Manor Care Ruxton |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |                                 | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 3336 Cardenas Ave 21213   |  |  |  |   |                                 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Birner  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Theresa Stengle  |                                 |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>212-03-8211  |  | 17. INFORMANT ADDRESS<br>D.J.Hochrein Sr. 413 Cedarcroft Road 21212   |                                 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>stroke</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                                 |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |                                 |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                 |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>7/17/84 84 7/22/84 84  |                                 |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/18/84 to 7/22/84, that (I) (we) last saw the deceased alive on 8/18/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death.  |  |  |  |   |                                 |   |  |
| 22b. SIGNATURE<br><u>Vuong Vu Nguyen</u> DEGREE  |  |  |  | 22c. DATE SIGNED<br>7/23/84   |                                 | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Vuong Vu Nguyen  |  |
| 22e. ADDRESS<br>6331 Belair Road   |  |  |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |                                 |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7-24-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer  |                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home 6500 York Road 21212   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 24 1984  |                                 | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>  |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                              |  |  |  |  |  |  |  | REG. NO.  |  |
|---|--|------------------------------|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>GERHARD AUGUST HOFFMANN, JR.</b>  |  |                              |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 24 1984</b> |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>         |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>1 28 1964</b>   |  | 6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS <b>20 YRS.</b>                                   |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |                              |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.                            |  |
| 10. CITY OR TOWN OF DEATH <b>Dundalk</b>  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4000 Beechwood Road</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pumped Gas</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Truck Stop</b>   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                              |  |  |  |  |  |  |  | 12c. STREET ADDRESS <b>21222</b>  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b> |  | 13c. CITY OR TOWN <b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>3804 North Point Road</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Gerhard August Hoffmann, Sr.</b>   |  |                              |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary C. Fink</b>                               |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |  |                              |  | 16b. SOCIAL SECURITY NO. <b>215-96-6479</b>  |  | 17. INFORMANT <b>Gerhard A. Hoffmann, Sr.</b>  |  | ADDRESS <b>Same as 13e</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                              |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                              |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>2300 P.M. 7 24 1984</b>   |  |                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2300 P.M. 7 24 1984</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Diverted automobile exhaust</b>   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4000 Beechwood Rd., Balto., Md. 21222</b>  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                              |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>  |  |                              |  |  |  | TITLE (SPECIFY) <b>Deputy</b>  |  | MEDICAL EXAMINER   |  | DATE SIGNED <b>7/25/84</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>   |  |                              |  |  |  | ADDRESS <b>2112 Dundalk Ave., Balto., Md. 21222</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                              |  | 23b. DATE <b>7/27/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>                                 |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>                           |  |
| 24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc</b>   |  |                              |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>  |  |   |  |
| 7922 Wise Avenue Dundalk, MD. 21222   |  |                              |  |  |  |  |  |  |  |   |  |

ALAN NORTH TELSON (REAR)



RECEIVED  
JUN 10 1964



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |  |   |   |   |  |   |  | REG. NO.  |  |
|---|-------------------------|---|--|---|---|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |                         | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOROTHY JANE HOOVER</b>  |  |   |   |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>7 10 1984</b> |  | 2b. HOUR <b>AM</b>  |  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/14/1931</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br><b>52</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>  | 2c. DATE PRONOUNCED DEAD<br><b>7 11 1984</b>  |  | 2d. HOUR <b>2115</b>  |  | 2e. MIN. <b>AM</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>                                 |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>DUNDALK</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3455 LIBERTY PARKWAY 21222</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESPERSON</b> |   |  | 12b. KIND OF BUSINESS<br><b>COSMETICS</b>   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |                         | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3455 LIBERTY PARKWAY 21222</b>                                  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ERNEST (nmi) SHAW</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CLARA ELIZABETH BOWMAN</b>  |   |   |  | 16. ADDRESS<br><b>4207 KEVIN ROAD</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>170.26.4018</b>  |  | 17. INFORMANT<br><b>RALPH W. HOOVER, JR. HAWRE de GRACE, MD.</b>  |   |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |  |   |   |   |  |   |  | APPROXIMATE TIME BETWEEN DEATH AND EXAMINATION<br><b>21078</b>                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>J. Crossan O'Donovan</b>   |                         | M.D. <b>Deputy</b>  |  | MEDICAL EXAMINER<br><b>2112 Dundalk Ave., Balt., Md. 21222</b>  |   |   |  | DATE SIGNED<br><b>7/14/84</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>  |                         | ADDRESS   |  |   |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>7/17/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEMETERY</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>                        |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222</b>   |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 16 1984</b>   |   |   |  |   |  |   |  |



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1. The first part of the report is a summary of the work done during the year. It includes a list of the projects completed and a brief description of the results. The second part is a detailed account of the work done on each project. It includes a description of the methods used, the results obtained, and a discussion of the significance of the work.

2. The first project was the study of the effect of temperature on the rate of reaction between hydrogen peroxide and potassium iodide. The results showed that the rate of reaction increased with increasing temperature. The second project was the study of the effect of concentration on the rate of reaction between hydrogen peroxide and potassium iodide. The results showed that the rate of reaction increased with increasing concentration.

3. The first project was the study of the effect of temperature on the rate of reaction between hydrogen peroxide and potassium iodide. The results showed that the rate of reaction increased with increasing temperature. The second project was the study of the effect of concentration on the rate of reaction between hydrogen peroxide and potassium iodide. The results showed that the rate of reaction increased with increasing concentration.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | Item #14 Film #G593<br>7/26/84 jp   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 84 18123  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>MABEL G HORGAN</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>7 23 84</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Mar. 8, 1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>88</b>  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO County MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Sang Zang</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Catherine Kirchner</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4918 Arabia Ave 21214</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Mrs. H Janet Marshall 604 St Dunstons RD 21212</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 19 83</b> to <b>July 23 19 84</b> , that (I) (we) last saw the deceased alive on <b>July 23 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>DR Faulkner MD</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/26/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leonard J. Ruck Inc</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1984</b>  |  |   |  |
| ADDRESS<br><b>Baltimore, Md</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Sue Davidson-Randall</b>   |  |   |  |

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Interference in the ...

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JUL 2 8 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 1 8 1 2 4

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                              |   |  |
|---|--|---|---|---|------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALVEY HARP HORINE, SR.</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 13, 1984</b> |   | 2b. HOUR<br><b>100 A. M.</b> |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 3, 1906</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Nook Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Rep.</b>   |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Food Brokerage</b>  |  |

|  |  |  |   |  |  |  |   |  |   |  |  |
|--|--|--|---|--|--|--|---|--|---|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8417 B. Loch Raven Blvd. 21234</b>                              |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alvey J. Horine</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Flook</b> |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   |  | 16b. SOCIAL SECURITY NO.<br><b>220-05-3360</b>  |  |  |
| 17. INFORMANT<br><b>Alvey H. Horine, Jr.</b>   |  |  | ADDRESS<br><b>Westminster, Md. 21157</b>                                |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF, (b) <b>A.B.C.V.D. with Abdominal Aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF, (c) <b>Peritonitis Urinary Bladder</b> |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1982</b><br><b>1982</b><br><b>1982</b> |  |  |

|  |  |  |  |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                      |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1982</b><br><b>7/13/84</b>   |  |

|   |  |  |  |
|---|--|--|--|
| 22a. I certify that (I) (the undersigned) attended the deceased from <b>7/13/84</b> to <b>7/13/84</b> , that (I) (the undersigned) saw the deceased alive on <b>7/13/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the undersigned did not view the body after death) |  |  |  |
| 22b. SIGNATURE<br><b>William E. McGrath, M.D.</b>   |  | 22c. DATE SIGNED<br><b>7/13/84</b>         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William E. McGrath, M.D.</b>  |  | 22e. ADDRESS<br><b>1303 Frederick Road</b> |  |

|  |  |                             |  |   |  |  |  |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                             |  | 23b. DATE<br><b>7-16-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Methodist</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Myersville Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 17 1984</b>             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John W. ...</b>                         |  |

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September 2, 1906

U.S.A.

Maryland

Food Machine

Calder Nov.

21231 H. Loch Raven Blvd. 21231

Maryland

Block

Minister

Fortne

Alvey

Westminster, Md. 21237

Alvey H. Fortne, Cr.-1532 G. Pleasant Valley

220-03-3360

No

7-16-84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
(IMPORTANT: If item 21 is marked on item 1B, the medical examiner must be notified at once.)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

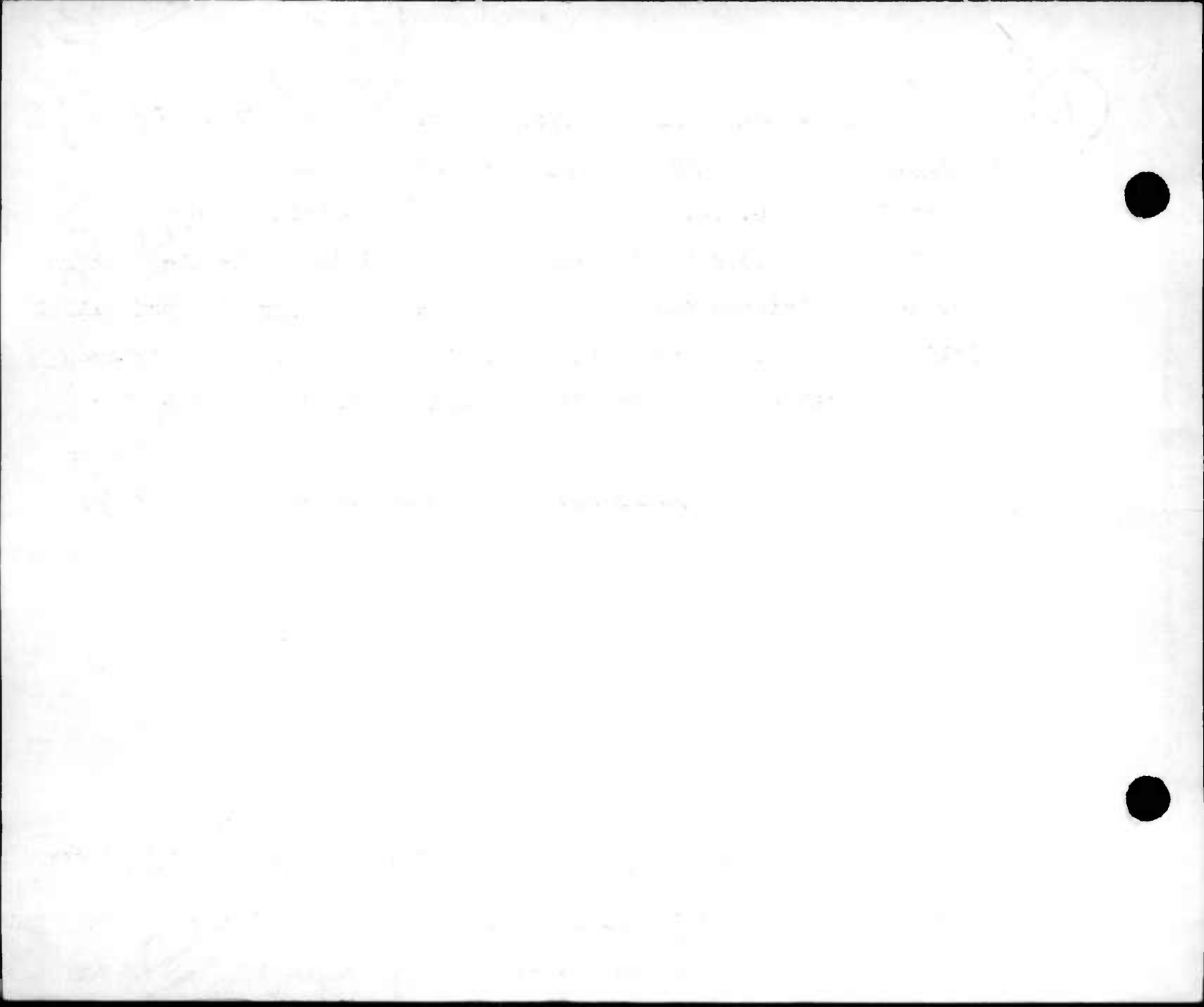
8 4 1 8 1 2 5

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |  |
|---|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William C. Hose, Jr.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 11 84</b> |   |  | 2b. HOUR<br>MIN.<br><b>7 55 P</b>   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 4 61</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>22</b> YRS.   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1952 Quentin Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Military-Disabled Veteran</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William C. Hose, Sr.</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sheila J. Sirbough</b>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1952 Quentin Road 21222</b>  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1979-1982</b>   |   | 17. INFORMANT<br><b>Vincent Belcastro</b>   |  | Same as 13e   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>METASTATIC SARCOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 MIN.</b><br><b>1 yr.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Mohamed A. Al-Rattim</b> DEGREE  |  |   |   |   |  | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mohamed A. Al-Rattim</b>  |  |   |   |   |  | 22e. ADDRESS<br><b>Baltimore VA 3900 Col Rd<br/>MD 21218</b>                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/14/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Mary</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.<br/>7922 Wise Avenue Dundalk, MD. 21222</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 16 1984</b>   |  |   |  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  | 8 4 1 8 1 2 6  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| JOHN RAYMOND HUCKE  |  |  |  | 7 9 84   |  | 545 A  |  | M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |  |
| Male  |  | White  |  | April 30, 1903   |  | 81   |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Baltimore Md.   |  | U.S.A.   |  |  |  | Baltimore County MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Towson  |  | St. Josephs Hospital   |  |  |  | Retired  |  | Grocer  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS   |  |
| Maryland  |  | Baltimore  |  | Baltimore  |  |  |  | 8521 Wateroak Rd 21234  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |
| late William L Hucke  |  |  |  | late Bertha A Heise  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |
| No  |  | 217 16 4343  |  | John C McFarlane 8614 N. Bali Ct Ellicott City 21043   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) <u>INTRACEREBRAL BLEED</u>  |  |  |  |  |  |  |  | 3 DAYS  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.  |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
|   |  | P.M. 19  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC)                                       |  | 21f. LOCATION STREET   |  | CITY OR TOWN   |  | COUNTY STATE  |  |
|   |  |  |  |  |  |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>July 6</u> , 19 <u>84</u> , to <u>July 8</u> , 19 <u>84</u> , that (1) we) lost saw the deceased alive on <u>July 8</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| <u>[Signature]</u>  |  | M.D.   |  |  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |   |  |
| EDWARD P. KOBA  |  | 7801 YORK RD., TOWSON, MD.   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN   |  | STATE   |  |
| Burial  |  | July 12, 1984  |  | Loudon Park  |  | Baltimore Maryland   |  |   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REGD. BY REGISTRAR   |  | 25b. REGISTRAR'S NAME  |  |   |  |
| Harry H Witzke 4112 Columbia Rd Ellicott City   |  |  |  | JUL 11 1984  |  |  |  |   |  |



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|                      |  |           |                        |                  |
|----------------------|--|-----------|------------------------|------------------|
| Male                 | Baltimore Md.                                | White     | April 30, 1903         | 81               |
| Towson               | Baltimore Md.                                | U.S.A.    | x                      | Baltimore County |
| Retired              | St. Josephs Hospital                         | Retired   | Grocer                 |                  |
| Maryland             | Baltimore                                    | Baltimore | 8521 Waterock Rd 21234 |                  |
| Late William L Hucks | Late Bertha A Helms                          |           |                        |                  |
| No                   | 217 16 4343 John C McFarlane 8514 W. Ball CE |           |                        | 21043            |

Handwritten notes and stamps at the bottom of the page, including a large circular stamp on the left and various signatures and dates.

July 12, 1984 London Park  
Baltimore Maryland  
July 1, 1984  
Baltimore City



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                 |  |   |  |  |  |   |  | REG. NO. 4 18127  |  |   |  |
|---|--|---------------------------------|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ERNEST T. HURLEY</b>   |  |                                 |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR<br><input checked="" type="checkbox"/> 7 19 84 |  | 2b. HOUR<br>2:30 AM   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>         |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>07 15 11</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>73 YRS.</b>                                |  | IF UNDER 1 YR. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>7 19 84</b>                                       |  | 2d. HOUR<br>2:30 AM   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  |                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO County</b> MD.                                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ARBUTUS</b>   |  |                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1129 LINDEN AVENUE, 21227</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPERINTENDENT</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MARYLAND PORT AUTHORITY</b>   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                                 |  |   |  |  |  |   |  |   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b> |  | 13c. CITY OR TOWN<br><b>ARBUTUS</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1129 LINDEN AVENUE, 21227</b>   |  |   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>E. E. HURLEY</b>  |  |                                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LILLIAN THAW</b>   |  |  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>NO</b>   |  |                                 |  | 16b. SOCIAL SECURITY NO.<br><b>223-03-7055</b>  |  | 17. INFORMANT ADDRESS<br><b>LUCY H. HURLEY 1129 LINDEN AVENUE 21227</b>                      |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>gun shot wound thru head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                                 |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                                 |  |   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>P.M. 19  |  |                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                                 |  |   |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>E.P. Williamson</b>  |  |                                 |  | TIME (SPECIFY)<br><b>Repsy</b>  |  |  |  | MEDICAL EXAMINER<br><b>Repsy</b>  |  |   |  | DATE SIGNED<br><b>7/19/84</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>E.P. Williamson</b>   |  |                                 |  | ADDRESS<br><b>5550 BALTIMORE NATIONAL PIKE, 21228</b>   |  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>REMOVAL/BURIAL</b>  |  |                                 |  | 23b. DATE<br><b>07-23-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FOREST LAWN</b>                                     |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>RICHMOND HENRICO VIRGINIA</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |                                 |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 20 1984</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |

ARBUTUS

MARYLAND

BALTIMORE

HURLEY

E.

E.

223-03-7022

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |        |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
|---|--------|--|--|---|--|---|--|--------------------------------------|--|--------------------------|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |        | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH              |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR  |  |
| Thomas Russell Jackson, Jr.   |        |  |  |   |  |   |  | 7/14/84                              |  |                          |  |       |  |      |  | M         |  |
| 3 SEX   | 4 RACE | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR      |  |
| M   | W      | 8/14/59  |  | 24 YRS.   |  |   |  |                                      |  | 7/14/84                  |  |       |  |      |  | 12:15 A M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |        | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                          |  |       |  |      |  |           |  |
| MD.   |        | USA  |  | WIDOWED   |  | DIVORCED  |  | Baltimore County                     |  |                          |  |       |  |      |  | MD.       |  |
| 10 CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |                          |  |       |  |      |  |           |  |
| ESSEX Dundalk   |        | 729 Seawall Rd.  |  | TAINEE  |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 13a. STATE  |        | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |                          |  |       |  |      |  |           |  |
| MD  |        | BALTO  |  | ESSEX   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 729 SEAWALL RD                       |  |                          |  |       |  |      |  |           |  |
| 14. FATHER'S NAME   |        | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| THOMAS R. JACKSON SR  |        | MARY L CONDEN  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |        | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                      |  |                          |  |       |  |      |  |           |  |
| UNK   |        | 250 792751   |  | MARY JACKSON  |  | ABOVE   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| PART I DEATH WAS CAUSED BY:   |        | Undetermined   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| IMMEDIATE CAUSE (a)   |        | DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |        | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| (c)   |        |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d). |        |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 19a. DATE OF OPERATION  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                      |  |                          |  |       |  |      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                 |        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK     |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET  |  | CITY OR TOWN  |  | COUNTY                               |  | STATE                    |  |       |  |      |  |           |  |
| 22a. I certify that I took charge of the remains described above, held on   |        | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| death resulted from:  |        | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| ACTUAL SIGNATURE  |        | TITLE (SPECIFY)  |  | DATE SIGNED   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| Margarita A. Korell, M.D.   |        | M.D. Assistant   |  | 7/15/84   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |        | ADDRESS  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| Margarita A. Korell, M.D.   |        | 111 Penn St., Balto., Md. 21201  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |        | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY                               |  | STATE                    |  |       |  |      |  |           |  |
| BURIAL  |        | 7/17/84  |  | LORRAINE PARK   |  | BALTO. MD.  |  |                                      |  |                          |  |       |  |      |  |           |  |
| 24. FUNERAL DIRECTOR NAME   |        | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                      |  |                          |  |       |  |      |  |           |  |
| J.G. CONNELLY   |        | 300 SONS MALE  |  | JUL 16 1984   |  | Julia Davidson-Randall  |  |                                      |  |                          |  |       |  |      |  |           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 2 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br>A/K/A Margaret Carol Jendrek<br>Carol D Jendrek |   |   | 2a. DATE OF DEATH<br>7 19 84 6:55 AM  |   |   |
| 3. SEX<br>Female  | 4. RACE<br>W. white   | 5. DATE OF BIRTH<br>7 28 16   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS   |   | 7b. HOUR<br>55  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. County MD  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. Joseph Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bd of Ed. (Ret)                |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Education              |
| 13a. STATE<br>Md.   | 13b. COUNTY<br>Balto  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>4507 Fullerton Ave. 21236 |
| 14. FATHER'S NAME<br>FIRST: Sylvester A. Donegan                                    |   | 15. MOTHER'S MAIDEN NAME<br>FIRST: Catherine M. Dwyer   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No             |   | 16b. SOCIAL SECURITY NO.<br>158-07-4672   |   | 17. INFORMANT<br>Eugene F. Jendrek 4507 Fullerton Ave 21236 |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) shock

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) cardiovascular accident

DUE TO, OR AS A CONSEQUENCE OF

(c) Embolization for Left ventricular thrombusAPPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
2 days

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br>Calvin Plitt  |  | DEGREE<br>M.D.   | 22c. DATE SIGNED<br>7/19/84  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Calvin Plitt, M.D.   |  | 22e. ADDRESS<br>St. Joseph Hospital Towson, Md.                                      |  |

|  |                            |  |  |
|--|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial        | 23b. DATE<br>July 21, 1984 | 23c. NAME OF CEMETERY OR CREMATORY<br>Cathedral Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Homes, Inc. |                            | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.            | 25a. DATE REC'D. BY REGISTRAR<br>JUL 20 1984                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418130

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |                            |  |
|--|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Nellie Johnson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-27-84</b> |   | 2b. HOUR<br><b>1:30 PM</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 13 14</b>  |                            |  |
| 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>70</b> YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>   |   | 8. AGE IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>20</b> MONTHS <b>20</b> DAYS  |                            |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>Balt</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Inglebrook 333 Haden Lane</b> |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   | 13. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore CO MD.</b>  |                            |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALT</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Laurance ? Story</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie ? Story</b>                              |   | 16. ADDRESS<br><b>Catonsville, Md., 21228</b>   |                            |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 17b. SOCIAL SECURITY NO.<br><b>270-05-0469</b>  |   | 17c. INFORMANT<br><b>Earl M. Johnson, 1512 Rolling Rd., N</b>   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Attack</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>diabetes</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerosis</b> |  |   |   |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>   |  |   |   |   |                            |  |
| 19a. DATE OF OPERATION<br><b>7/27/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Heart Attack</b>                             |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                              |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>84 7/17 /m 84</b> to <b>7/27 84</b> , that (I) (we) lost saw the deceased alive on <b>7/27 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                            |  |
| 22b. SIGNATURE<br><b>MARC DAVIS</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>7/27/84</b>  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARC DAVIS</b>   |  | 22e. ADDRESS<br><b>907 BALT MA Pice EL MD</b>   |   |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>30 July 84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Mem. Gardens</b>   |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bel Air Harford Maryland</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Tarring Funeral Home, P.A., Aberdeen, MD, 21001-1100</b> |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 01 1984</b>   |                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rendall</b>   |  |   |   |   |                            |  |







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 3 1

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |                            |   |  |                                    |  |  |  |
|---|--|----------------------------|---|--|------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                            | 2a. DATE OF DEATH   |  |                                    | 2b. HOUR   |  |  |
| FIRST MIDDLE LAST<br>FRANCIS A JORDAN   |  |                            | MONTH DAY YEAR<br>07 04 84  |  |                                    | 5:30AM   |  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH           | 6. AGE (IN YEARS (LAST BIRTHDAY))   |  |                                    | 7. IF UNDER 1 YEAR   |  |  |
| MALE  | W  | MONTH DAY YEAR<br>03 17 13 | 71 YRS  |  |                                    | MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   |                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |
| Pennsylvania  | U.S.A.   |                            |   |  |                                    | BALTIMORE COUNTY MD.   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| TOWSON, MD.   | GBMC 6701 N. CHARLES ST.   |                            |   |  |                                    |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                            | 13d. INSIDE CITY LIMITS?  |  |                                    | 13e. STREET ADDRESS / ZIP CODE   |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Pennsylvania Philadelphia   |  |                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                    | 1141 Anchor St. 19124  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Timothy Jordan  |  |                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>- - -  |  |                                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |                            | 16b. SOCIAL SECURITY NO.  |  |                                    | 17. INFORMANT ADDRESS  |  |  |
| Unknown   |  |                            | N/A   |  |                                    | Burns F/H 1428 E. Columbia Avenue  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>   |  |                            |   |  |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 MIN                         |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>CEREBRAL EDEMA AND DEEP COMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>MIDDLE AND POSTERIOR CEREBRAL ARTERY THROMBOSIS</u>  |  |                            |   |  |                                    | 2 DAYS   |  |  |
|   |  |                            |   |  |                                    | 4 WEEKS  |  |  |
|   |  |                            |   |  |                                    |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PREVIOUS SEPTICEMIA, HEART FAILURE</u>  |  |                            |   |  |                                    |  |  |  |
| 19a. DATE OF OPERATION  |  |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |                            |   |  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                            | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)  |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6/10</u> 19 <u>84</u> to <u>7/04</u> 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>7/04/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death. |  |                            |   |  |                                    |  |  |  |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE  |  |                            |   |  |                                    | 22c. DATE SIGNED   |  |  |
| <u>X</u>  |  |                            |   |  |                                    | 7/04/84  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                            |   |  |                                    | 22e. ADDRESS   |  |  |
| EMILIO B. LOBATO MD   |  |                            |   |  |                                    | GBMC-6701 N. CHARLES ST.   |  |  |
| 23a. BURIAL CREMATION, REMOVAL  |  |                            | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| CREMATION   |  |                            | 7/6/84  |  | Delaware Valley                    |  | Bucks Co., Pa.                             |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |                            |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |
| Wm C March F/H Inc. 1101 E North Avenue   |  |                            |   |  |                                    | JUL 5 1984   |  | <u>[Signature]</u>   |

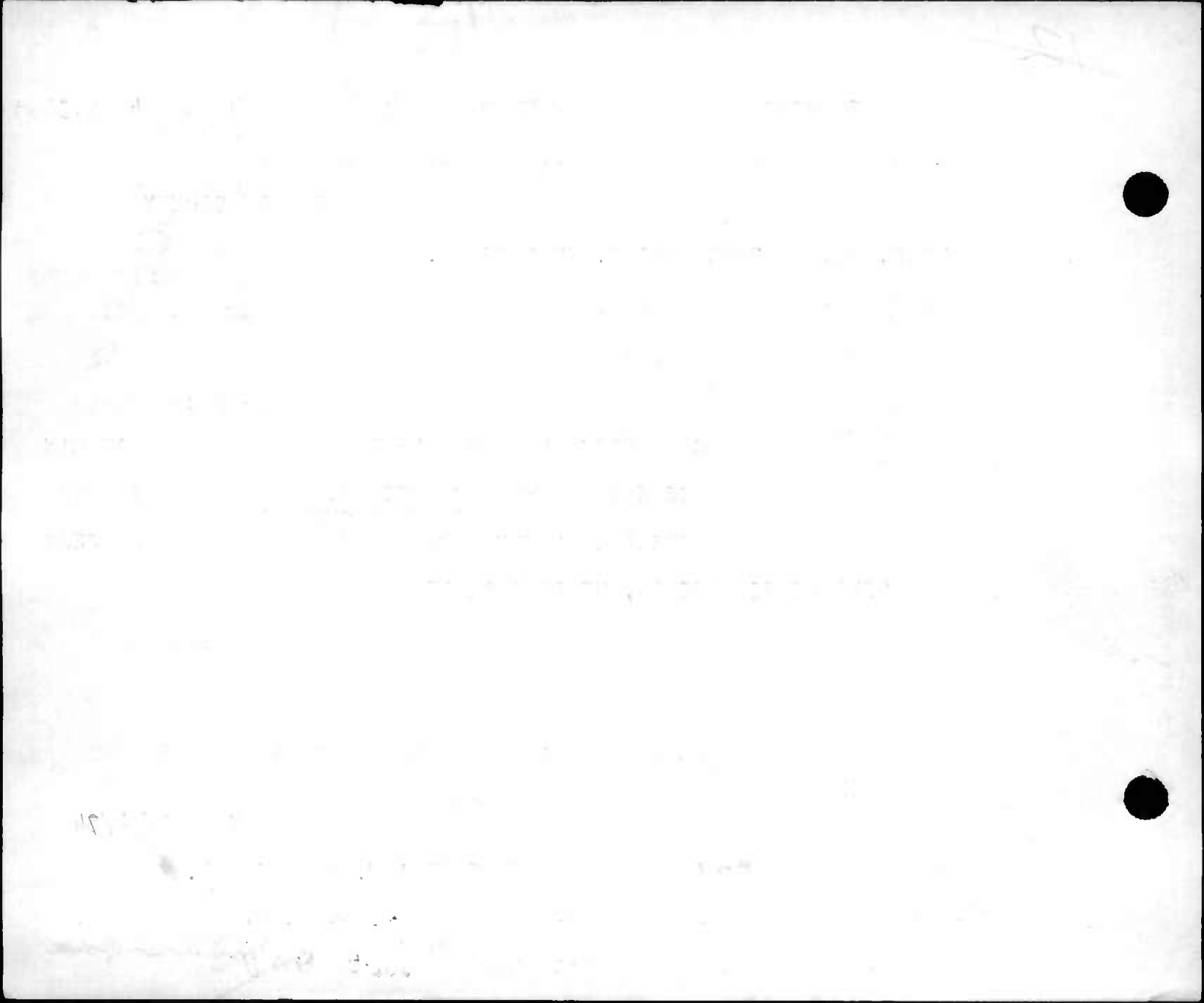
BP

DMMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 3 2

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JACK D. KAHLER</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>7 22 84</b>  |  | 2b. HOUR<br><b>5:25 P</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 7 21</b>                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>63</b>       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA MARIS Hospice</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>            |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-employed</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Cockeysville</b>                                       |  |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>12300 Happy Hollow Rd. 21030</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Walter Phillip Kahler</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sarah Elizabeth Bell</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-18-0030</b>  |  | 17. INFORMANT ADDRESS<br><b>Elizabeth H. Kahler - Same as #13e</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Eddie Naxhuda</b>  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>7-23-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>                          |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>1111 24 1984</b>                           |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>a. Davidson-Randall</b>  |  |   |  |  |  |

BP \_\_\_\_\_  
DMMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Yes

Wm H

214-18-0030

Elizabeth H. Taylor - same as #136

Walter

Philip

Kahler

Sarah

Elizabeth

Bill

Maryland

Baltimore

Cockeysville

X

12300 Happy Hollow Rd. 21030

Self-employed

Technical

U.S.A.

Maryland

JACK

D.

WILLIAM

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 3 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FANNIE KATZOFF</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>07 03 '84</b>                              |  | 2b. HOUR<br><b>9:15A M</b>                              |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 5 '41</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>                 |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b> |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY<br><b>7111/P/ Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Meyer Katzoff</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rachel Snyder</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-40-4099</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Ms. Sarah Katzoff - Same as #13</b>                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>FIBROSARCOMA WITH MULTIPLE METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)<br><b>G.I. BLEEDING</b>   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 7/3</b> , 19 <b>84</b> to <b>7/3</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |   |  |  |   |
| 22b. SIGNATURE<br><b>G. Bedon</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>7/3/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE BEDON, M.D.</b>   |  | 22e. ADDRESS<br><b>660 KENILWORTH DRIVE TOWSON 21204</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>7/3/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  | ADDRESS<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 6 1984</b>                                   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Randall</b>  |  |   |  |  |   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "a", item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 3 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Clara C. (HUFNAGEL) KEEFER   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 16, 1984  |  | 2b. HOUR<br>1:58 P.M.   |
| 3. SEX<br>FEMALE  | 4. RACE<br>CAUCASIAN  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 28 1928  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |   |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME                                      |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |
| 13a. STATE<br>MARYLAND  | 13b. COUNTY<br>BALTO  | 13c. CITY OR TOWN<br>ROSEDALE   | 13e. STREET ADDRESS / ZIP CODE<br>8111 POPLAR AVE. 21237  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES VINCENT GESLOIS   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>GRACE MARIE MONTRANGOLA  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>213263532   |   | 17. INFORMANT<br>ADDRESS<br>GEORGIANN LITTLE 309 POTOMAC AVE                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |   |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Intracerebral Hemorrhage  |   |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that X (this hospital) attended the deceased from July 15, 19 84, to July 16, 19 84, that X (we) last saw the deceased alive on July 16, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (did not) view the body after death. |   |   |   |  |   |
| 22b. SIGNATURE<br>Matthew Scott, M.D.   |   |   |   | 22c. DATE SIGNED<br>July 16, 1984  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Matthew Scott, M.D.  |   |   |   | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237                              |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |   | 23b. DATE<br>7/19/1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART JESUS                       |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO BALTO MD  |   | 23e. DATE REC'D. BY REGISTRAR<br>JUL 17 1984  |   |  |   |
| 24. FUNERAL DIRECTOR<br>J. J. Cook  |   | 25a. ADDRESS<br>1211 Chesaco Ave.   |   | 25b. REGISTRAR'S SIGNATURE<br>C. Davidson-Randall                              |   |

MEDICAL CERTIFICATION



THE C. (WING) (1940)

CHURCH

LAND

RECEIVED

RECEIVED

JAMES

NO

1940

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

FOR  
1- STATE  
REGISTRAR


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |  |   |   |   |
|--|-------------------------|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DALLAS WAYNE KEEFOVER</b>   |                         |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>7 15 84</b> |   | 2b. HOUR<br>M<br><b>0340</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 23 1962</b>                     | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>22 YRS.</b>        | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   | IF UNDER 24 HRS.<br>HOURS MIN<br><b>0 0</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                              |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>  |                         | 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>                                |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7637 Charlesmont Road</b>                  |   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Umpire-American</b>  |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Leagion</b>                        |   | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 13b. STATE<br><b>Maryland</b>  |                         | 13c. CITY OR TOWN<br><b>Dundalk</b>  |   | 13d. STREET ADDRESS<br><b>7637 Charlesmont Rd. 21222</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Dallas R. Keefover</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbara C. Powell</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>218-84-2199</b>                             |   | 17. INFORMANT ADDRESS<br><b>Dallas R. Keefover Same as 13c</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Strangulation + hanging</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                         |  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |  |   |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                          |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2200 7 15 1984</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Self-inflicted hanging</b>  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>7637 Charlesmont Rd. Balto. Md. 21222</b>   |   |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                         |  |   |   |   |
| ACTUAL SIGNATURE<br><b>J. Crossan O'Donovan</b>  |                         | TITLE (SPECIFY)<br><b>Deputy</b>   |   | DATE SIGNED<br><b>7/17/84</b>   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>J. CROSSAN O'DONOVAN</b>  |                         | ADDRESS<br><b>2112 DUNDALK AVE., BALT., MD 21222</b>                       |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>7/19/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Memorial</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>   |                         | ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>                      |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 18 1984</b>   |   |
|  |                         |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Items 18-22a 9/25/84 mtb F#595  |  |  |  |  |  |  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  | 1 8 1 3 6   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ALLEN W. KELLY <del>KELLEY</del> , Sr.  |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR<br>7 28 19 84  |  |  |  |  |  |  |  |  |  | M<br>4:10 P M   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>M   |  |  |  |  |  |  |  |  |  | 4. RACE<br>W  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct 18 1948   |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>35 YRS  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YR.<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN          |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Maryland  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk 21222  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>(car) 3125 Wallford Dr. 21222 |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Md Cup Co.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>Maryland  |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>---  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Baltimore City   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS<br>1530 Hollins St 2nd fl r21223                    |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter W. Kelly, Sr.  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Denise Atkins  |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>219-50-1395   |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS<br>21223<br>Denise Kelly/1839 McHenry St/Balto Md |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>3049 IMMEDIATE CAUSE (a) Narcotism<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____                           |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  |  |  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>   |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |  |  |  |  |  |  |  |  | DATE SIGNED<br>7-29-84  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |  |  |  |  |  |  |  |  | ADDRESS<br>111 Penn St., Balto., Md. 21201  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>08/01/84   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park   |  |  |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Howard County, MD 21227                           |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Walters Funeral Home/Pratt & Stricker Streets Balto Md 21223  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>AUG 3 1984 June Davidson  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | 8 4 1 8 1 3 7 |
|---|--|---|--|---|--|--|--|---|--|---------------|
| 1 - FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |  |  |   |  |               |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DANIEL JAMES KELLY, SR.</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JULY 4, 1984</b>                                      |  | 2b. HOUR<br><b>10:15a</b>   |  |               |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8/22/1898</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>85</b>                                |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO., MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE COUNTY</b> MD.                   |  |   |  |               |
| 10. CITY OR TOWN OF DEATH<br><b>DUNDALK</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2906 DUNMURRAY ROAD APT. B 21222</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FOREMAN</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL MEGR.</b>   |  |               |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2906 DUNMURRAY ROAD APT. B 21222</b>   |  |               |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN J. KELLY</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>S. AGNES FLAHERTY</b>  |  |  |  |   |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>213.07.2771A</b>   |  | 17. INFORMANT ADDRESS<br><b>DANIEL J. KELLY, JR. 5005 BERWYN ROAD COLLEGE PARK, MD.</b>   |  |  |  |   |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>AS EVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATELY BETWEEN ON <b>20740</b><br><b>6 month</b><br><b>15 years</b> |  |   |  |   |  |  |  |   |  |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>  |  |   |  |   |  |  |  |   |  |               |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |               |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/15</b> 19 <b>88</b> , to <b>6-15</b> 19 <b>84</b> , that (I) (we) lost <b>6/15</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |               |
| 22b. SIGNATURE <b>John V. Conway, M.D.</b> DEGREE <b>D.O.</b>   |  |   |  |   |  | 22c. DATE SIGNED<br><b>7/4/1984</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN V. CONWAY, M.D.</b>  |  |               |
| 22e. ADDRESS<br><b>3401 DUNDALK AVENUE DUNDALK, MARYLAND 21222</b>  |  |   |  |   |  |  |  |   |  |               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>7/5/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CREMATORY</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>                        |  |   |  |               |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 6 1984</b>   |  |   |  |               |
|   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                  |  |   |  |               |

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MCE 10

John C. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  | 8 4 1 8 1 3 8 |  |
|--|--|--|--|---|---|---|--|--|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |   |   |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Samuel Edward Kelly  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 5 84 |   |  | 2b. HOUR<br>2:00 P <sub>M</sub>  |  |               |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09 14 1890  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dulaney Towson Nursing Center |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. Transit Co.  |  |               |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Cockeysville   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1130 Greenway Rd. 21030  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Gregory Kelly   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Colita Pierson   |   |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-   |  | 17. INFORMANT<br>Dulaney Towson Nursing Center Records  |   | ADDRESS<br>111 West Rd. 21204   |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASCVD with Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Diabetes mellitus</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2+ yrs</u><br><u>2+ yrs</u>   |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |               |  |
| 22a. I certify that (I) (as hospital) attended the deceased from <u>7/11/84</u> 19 <u>84</u> , to <u>7/5</u> 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>7/11</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |  |               |  |
| 22b. SIGNATURE<br><u>Charles F. O'Donnell</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |   |  | 22c. DATE SIGNED<br><u>7/6/84</u>  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles F. O'Donnell, M.D.  |  |  |  | 22e. ADDRESS<br>7501 York Rd., 21204  |   |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7/9/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Balto. City Md.   |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Martin D. Lawson, 10 W. Padonia Rd. 21093  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 6 1984   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>                                      |  |  |  |               |  |



At the County Clerk's Office  
County of Kelly  
State of California  
I, the undersigned, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.

*Handwritten signature*  
*Handwritten signature*

Charles J. O'Donnell, M.C.  
County of Kelly  
State of California  
I, the undersigned, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on for an autopsy.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 84 18139   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 1. DECEASED NAME  |  |  |  |
| FIRST MIDDLE LAST<br>Lucille M Kennedy   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>7 28 84   |  |  |  |
| 3. SEX<br>Female   |  |  |  | 4. RACE<br>Black  |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>6 13 1921   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |  |  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore  |  |  |  | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owner- Operator Nursing Home   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ned Williams  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Eulisie Jones   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No.   |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-16-7954   |  |  |  |
| 17. INFORMANT<br>Evelyn A. Banks   |  |  |  | 2140 Pine Avenue<br>Baltimore, Maryland 21207   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma of breast (metastatic)</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized carcinomatous</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Gregory F. McAuliffe, M.D.   |  |  |  | 22c. DATE SIGNED<br>7-28-84   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gregory F. McAuliffe, M.D.  |  |  |  | 22e. ADDRESS<br>Balto Co Gen Hosp Randallstown Md   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>8/3/84   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |  |  |
| 24. FUNERAL HOME OR PERSONAL SERVICE<br>Nutter & Sons 2501 Gwynns Falls Parkway<br>Funeral Home Inc. Baltimore, Maryland 21216   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 31 1984  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>William R. Anderson  |  |  |  |   |  |  |  |

1957-1958, 1959-1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 84 18140<br>REG. NO.  |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Helen D. Kimble</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 16, 1984</b>   |  |   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 28 1894</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Valley Nurs. Conv. Ctr.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gordon Cartons</b>  |   |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>-----</b>   |  | 13c. CITY OR TOWN<br><b>City</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William FRANK Downes</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Rhoades</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5801 B Western Run Dr. 21209</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>----- 217-20-9212A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Jane Massicot 2717 Cheswold Rd. 21209</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a   |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12</b> 19 <b>82</b> to <b>7-16</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7-11</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Thomas C. Kuwalewski MD</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>7-17-84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M-C. KUWALEWSKI MD</b>   |  |   |  | 22e. ADDRESS<br><b>8604 HARPORT RD</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7-19-1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore -- Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee - Henss</b>  |  |   |  | ADDRESS<br><b>3631 Falls Rd. 21211</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 18 1984</b>   |   |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 1 8 1 4 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

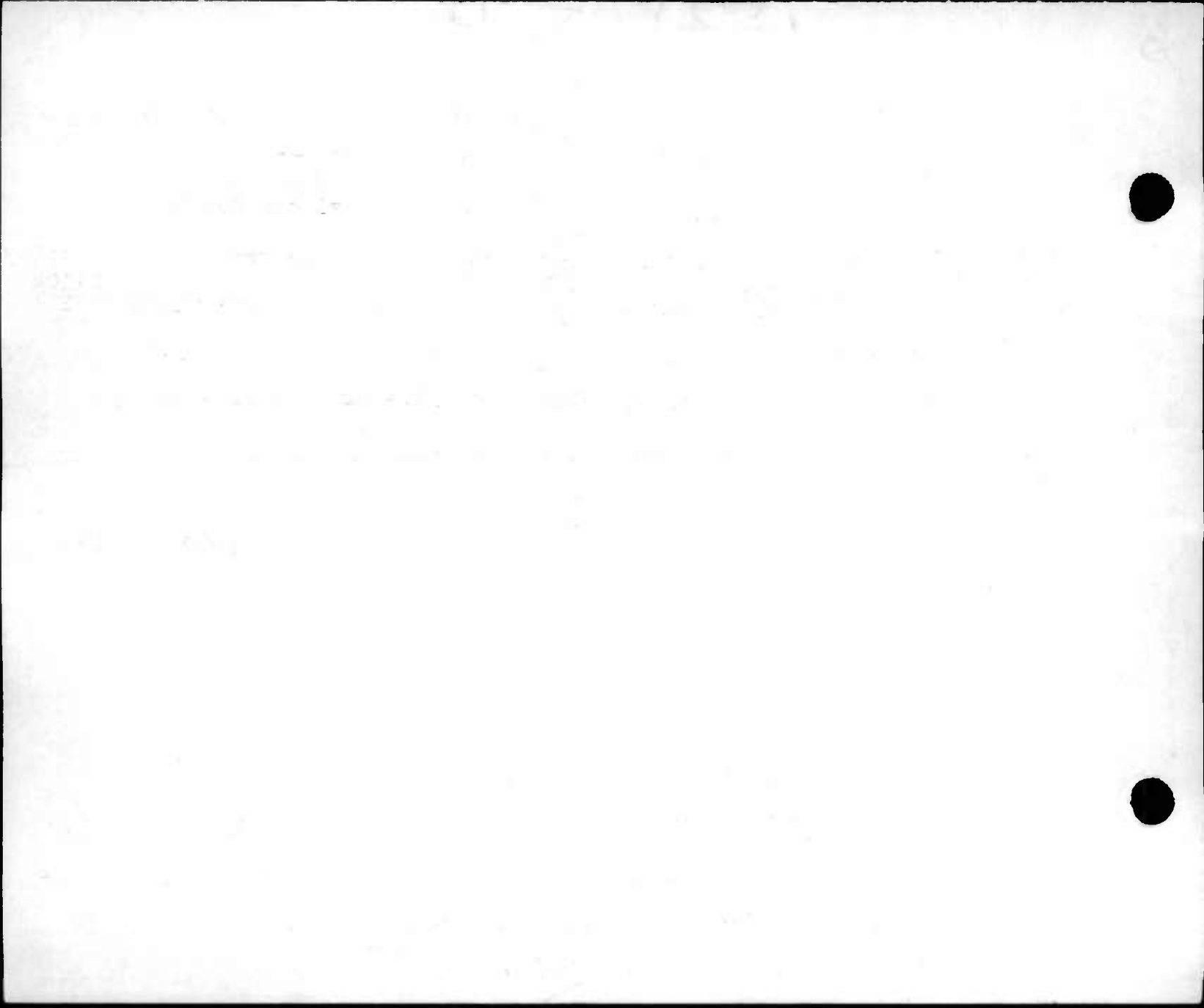
|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MILFORD KINSLER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 26 84   |   |  | 2b. HOUR<br>6:06 PM  |  |   |  |
| 3 SEX<br>Male  |  | 4. RACE<br>Caucasin   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 15 1918  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tennessee   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto County Gen Hosp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employ  |  |
| 13a. STATE<br>Md.  |  | 13b. CITY OR TOWN<br>Carroll  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS & ZIP CODE<br>7424 Marlottsville Rd 2 21104                |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Vincent Kinsler  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maude Feuget  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |   | 16b. SOCIAL SECURITY NO.<br>414-16-3822  |   |  | 17. INFORMANT<br>ADDRESS<br>Elsie Kinsler Same as # 13                         |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac asystole</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Ruptured aneurysm abdominal</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br>Hafeez D. Syed   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>7/26/84  |  |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HAFAEEL SYED  |  |   | 22e. ADDRESS<br>BALTIMORE COUNTY GEN HOSP  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |   | 23b. DATE<br>7-27-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process |  | 23d. LOCATION<br>CITY OR TOWN STATE<br>Catonsville Md. |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MacNabb Funeral Home Catonsville, Md.  |  |   |  |   |  | 25. DATE RECEIVED BY REGISTRAR<br>JUL 27 1984                                  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

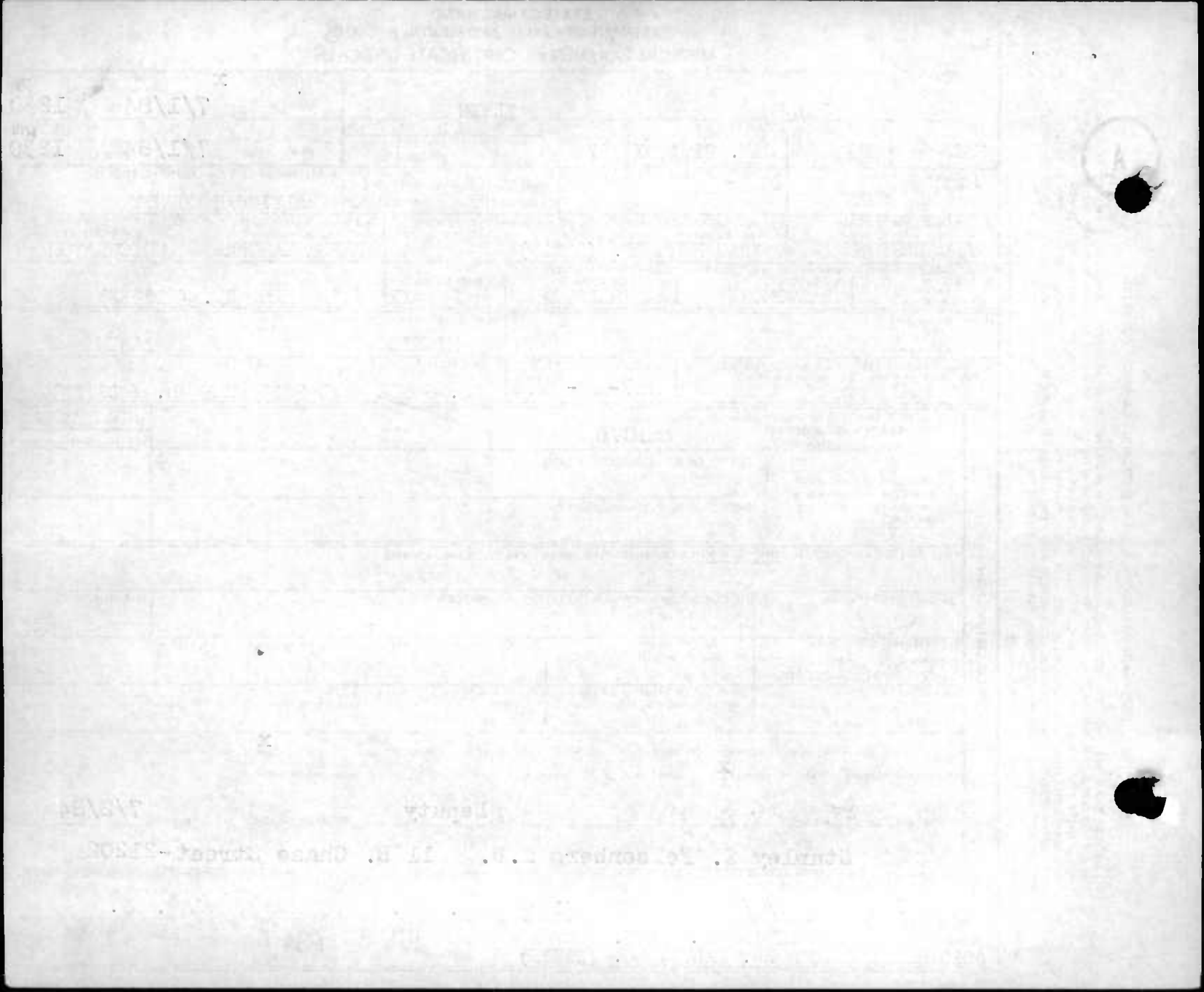
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DPHM - 17  
(VR A15 ME (5))  
15M 7/76

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |  |  |   | REG. NO.   |  |
|--|--|-------------------------|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH M KLEIN</b>  |  |                         |  |  |  |   |  |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>7/1/84</b> |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b> |  | 5. DATE OF BIRTH<br>MONTH <b>JAN.</b> DAY <b>21</b> YEAR <b>1897</b> |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>87</b> YRS.   |  | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>         |   | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD. |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3810 NEMO RD. (21133)</b> |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PAPER HANGER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DECORATOR</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |                         | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>RANDALLSTOWN</b> |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3810 NEMO RD. ( 21133)</b>                |  |  |
| 14. FATHER'S NAME<br>FIRST <b>NATHAN</b> MIDDLE <b>WANK</b> LAST <b>WANK</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MINNIE</b> MIDDLE <b>KLEIN</b> LAST <b>KLEIN</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>217-20-8173</b>                       |  | 17. INFORMANT ADDRESS<br><b>MRS. SONIA MATZ 3810 NEMO RD. ( 21133)</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>ASCVD</b>  |  |                         |  |  |  |   |  |  |   |  |  |
| IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. _____<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____   |  |                         |  |  |  |   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |                         |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                    |  |   |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |  |   |  |  |
| ACTUAL SIGNATURE <i>Stanley Z. Felsenberg</i> M.D.   |  |                         |  |  |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  | MEDICAL EXAMINER   |   | DATE SIGNED <b>7/2/84</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Stanley Z. Felsenberg M.D.</b>  |  |                         |  |  |  | ADDRESS <b>11 E. Chase Street-21202</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         |  | 23b. DATE<br><b>7/3/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH CONG. CEM.</b>   |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WOODLAWN, BALTO. MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS.</b><br><b>6010 REISTERSTOWN RD. BALTO, MD. (21215)</b>  |  |                         |  |  |  | 25. DATE RECD. BY REGISTRAR<br><b>JUL 6 1984</b>  |  | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i>   |   |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418143

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VIVIAN RUTH KNEIS</b>                      |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 26, 1984</b>                          |   | 2b. HOUR<br>M   |
| 1. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 23, 1922</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |   |
| 10. CITY OR TOWN OF DEATH<br><b>DUNDALK</b>                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8608 SANDY PLAINS Rd</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1454 BATTERY Ave</b>                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexis L. PIERSON</b>                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth E. Jarboe</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-16-1555</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Betty Bush 2824 Hudson ST</b>                                    |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 HOUR</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-31, 1970</b> to <b>Present</b> , that (I) (we) lost<br>saw the deceased alive on <b>2-24-70</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) sew the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Marc S. Posner</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>7/27/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARC S. POSNER MD.</b>   |  | 22e. ADDRESS<br><b>107 E. West ST</b>                                  |  |  |   |

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> | 23b. DATE<br><b>7/30/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Balto Md</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hartley Miller</b>         |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 30 1984</b>     |   |
| ADDRESS<br><b>7527 Harford Rd</b>                             |                             | 25b. REGISTRAR'S SIGNATURE<br><b>John Barker</b>        |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 may be retained by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 4 4

REG. NO.

|   |  |   |   |   |  |  |   |   |   |  |
|---|--|---|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Raymond Knipp  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 12 84  |   |  | 2b. HOUR<br>10:50 P.   |   |   |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasion  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 22 00   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. Co. MD.                                     |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Towson Manor Care Nursing Home |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Auditor - Mass Transit |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br>Md.   |  |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>2523 Hamilton Avenue 21214 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis F. Knipp  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elsie Beckmeyer  |   |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-05-9898  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Edith F. Knipp 2523 Hamilton Ave 21214        |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) - Alzheimer's disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br>- ASCVD. |  |   |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on 7/12/84 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br>W. H. Jones   |  |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>7/13/84  |   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KHIN - M. TUN  |  |   | 22e. ADDRESS<br>Manor Care Towson.  |   |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>July 16, 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck Inc. Baltimore, Maryland  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 16 1984                                   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |   |   |  |

BP \_\_\_\_\_

(A)

(B)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 4 1 8 1 4 5   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>Mrs. Bessie K. Kosko</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 1 1984</b>  |  | 2b. HOUR <b>A</b><br><b>6:25 M</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>January 25 1901</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>83</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13e. STREET ADDRESS<br><b>3626 Lockwood Rd.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert Kantner</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie (Graeff) Kantner</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>166-03-3324</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr. Michael J. Kosko Sr.</b>  |  | 21207   |  |
|  |  |  |  | <b>3626 Lockwood Rd.</b>  |  | <b>Baltimore Maryland</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>3 aplenicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>carcinoma of the cervix</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 30, 1984</b> to <b>July 1, 1984</b> , that (I) (we) last saw the deceased alive on <b>June 30, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Sharon Pournotabed, M.D.</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>7-1-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GHASSEM POURNOTABED</b>  |  |  |  | 22e. ADDRESS<br><b>Balto. Co. General Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-3-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Eldersburg Carroll Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Loring Byers Funeral Directors, Inc.</b>   |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>JUL 3 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |
| 8728 Liberty Road Randallstown, Maryland 21133   |  |  |  |   |  |   |  |

A

31 November 1996

rely on:

10-65 art. 10-1

07-16-98

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 4 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

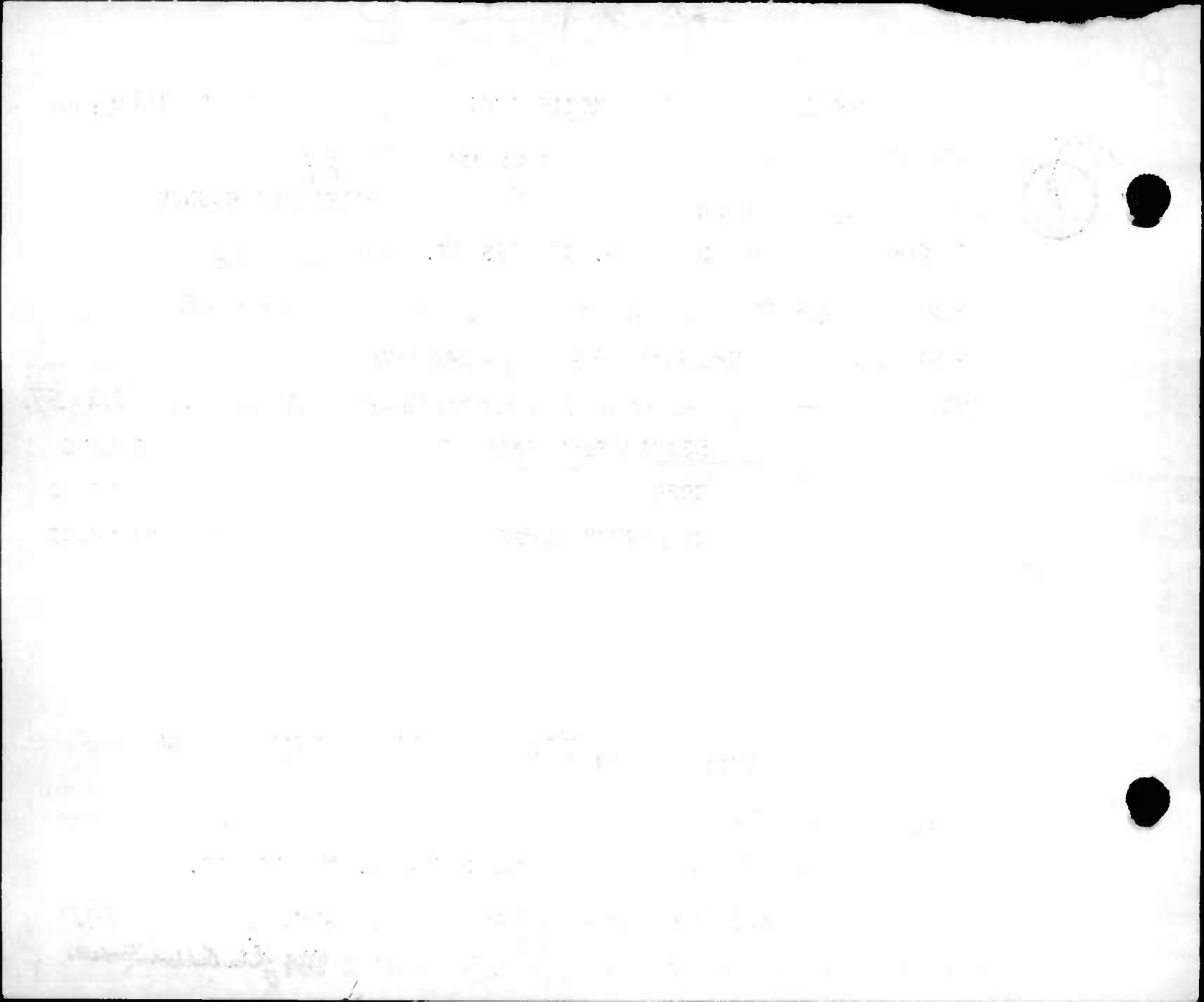
|  |  |  |  |   |  |  |   |  |   |  |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THERESA KOZIERACKI</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 31 '84</b>                 |   |  | 2b. HOUR<br>MIN.<br><b>2:00A</b>   |   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAU</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 21 '22</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>MD</b>  |  |  | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>PUNDALK</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6195. 47TH ST. 21224</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>IGNATIUS MACKOWIAK</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATHERINE</b>      |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-14-4819</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>VINCENT KOZIERACKI 6195. 47TH ST.</b>           |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b). <b>COPD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c). <b>CIGARETTE ABUSE</b> |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b><br><b>5 YEARS</b><br><b>25 YEARS</b>                         |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/06</b> , 19 <b>84</b> to <b>7/31</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/31</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Peter W. Townsend</b>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7-31-84</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter W. Townsend</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>8/3/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY CEM</b>                   |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>BALTO MD</b>                                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOHN M WEBER &amp; SONS INC</b>   |  |  | ADDRESS<br><b>4015 CHESTER ST.</b>                                     |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 2 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodale</b>   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 4 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGIA A. KREBS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 12 84</b>                                 |   | 2b. HOUR<br><b>1:03 P.M.</b>                                    |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 05 86</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>COUNTY BALTO MD.</b>                                 |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Carroll</b>   | 13c. CITY OR TOWN<br><b>Hampstead</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Spencer c. Krebs</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Cooper</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>10 RFD 2, Box 89B, August WV 26704</b>                     |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-14-1611</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>George F. Krebs Augusta, W. Va.</b>                              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASPIRATION PNEUMONIA.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/22/84</b> , 19 <b>84</b> , to <b>7-12/84</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/21/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |
| 22b. SIGNATURE<br><b>Tasneem Lakham</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>7/12/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TASNEEM LAKHAM</b>  |  | 22e. ADDRESS<br><b>5401, OLD COURT RD, RANBALSTOWN MD 21133</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>July 15, 84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grave Run Cemetery</b>                                 |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hampstead Balto. Co. Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 13 1984</b>   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Eline Funeral Home Hampstead, Md. 21</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>   |   |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 4 1 8 1 4 8   |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Emma S. Kress   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 22 84  |  | 2b. HOUR<br>M   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 23 07   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6901 Old Harford Rd. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bookkeeper                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Wm. Deitzis Co.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herbert O. Scribner  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma R. Shipley  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-07-0804  |  | 17. INFORMANT<br>ADDRESS<br>Lillian C. Erdman 2906D Kings Ridge Rd.<br>21234  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic Coronary Artery Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Hypertension</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.            |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>6/12</u> , 19 <u>84</u> , to <u>7-22</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>5-12</u> , 19 <u>84</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Marion C. Kowalewski MD</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>7/24/84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marion Kowalewski, MD   |  |   |  | 22e. ADDRESS<br>8604 Harford Rd. (668-7030)   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial  |  | 23b. DATE<br>7-26-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN Baltimore, Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LASSAHN FUNERAL HOME   |  |   |  | ADDRESS<br>1401 BELAIR RD. BALTO. MD. 21236   |  | REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  | REGISTRAR'S SIGNATURE  |  |

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*[Faint, mostly illegible handwritten text on lined paper. The text appears to be a list or series of entries, possibly related to a survey or inventory. Some words like "No." and "Date" are faintly visible at the top of the lines.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18149

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA E. KRUTSCH</b>                     |   |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>13</b> YEAR <b>84</b>                          |   | 2b. HOUR<br><b>1:55P.</b>                                    |
| 3 SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>10</b> YEAR <b>98</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>  | IF UNDER 1 YEAR<br>MONTHS <b>YRS.</b> DAYS <b>HOURS</b> MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE Co.,</b>                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERIDIAN NRSNG. CTR.-HERITAGE</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NURSING CENTER</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NURSING CTR.</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |   | 13b. COUNTY<br><b>---</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>-</b> LAST <b>Korsch</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elizabeth</b> MIDDLE <b>-</b> LAST <b>Koehler</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b> |   | 16b. SOCIAL SECURITY NO.<br><b>216-01-5621</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Lillian Englebrecht 700 S. Montford Ave. 21224</b>               |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (b) <b>Congestive Heart Failure</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 month</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last                                  |  | <b>years</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Renal Failure</b>   |  | <b>years</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>0</b>                        |  |   |

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/18</b> 19 <b>82</b> to <b>7/13</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/13</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>B. C. Veneracion Jr. MD</b>   |  | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>7/13/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. C. VENERACION JR MD</b>   |  | 22e. ADDRESS<br><b>3401 Dundalk Ave Baltimore MD 21224</b>                     |  |

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                    | 23b. DATE<br><b>July 16 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>LILLY &amp; ZELLER, INC. 1901 Eastern Ave. #21231</b> |                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 17 1984</b>            | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                        |



*[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side. Some words like "CO." and "1900" are visible.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 5 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |  |
|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANTOINETTE N. LAMBROS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 1, 1984</b>             |  | 2b. HOUR<br>M<br><b></b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 11, 1916</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b><br>YRS MONTHS DAYS<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Ruxton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>305 Southwind Road</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b><br>MD.   |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Ruxton</b>   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>305 Southwind Road 21204</b>      |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank P. Sperandeo, Sr.</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Lamartina</b> |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-40-7171</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Nicholas G. Lambros 305 Southwind Rd. 21204</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary carcinoma, possible</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>primary</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1981</b><br><b>1981</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Secondary aachalasia, pericardial + subpulmonic effusions</b>  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>5/3/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cardioesophageal obstruction</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6/30 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/20</b> 19 <b>69</b> to <b>July 1</b> 19 <b>84</b> . that (I) (we) lost<br>saw the deceased alive on <b>6/30</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Samuel Morrison, M.D.</b>  |  |  |  | 22c. DATE SIGNED<br><b>7/2/84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel Morrison, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>11 E. Chase Street</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-5-1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson</b>  |  |  |

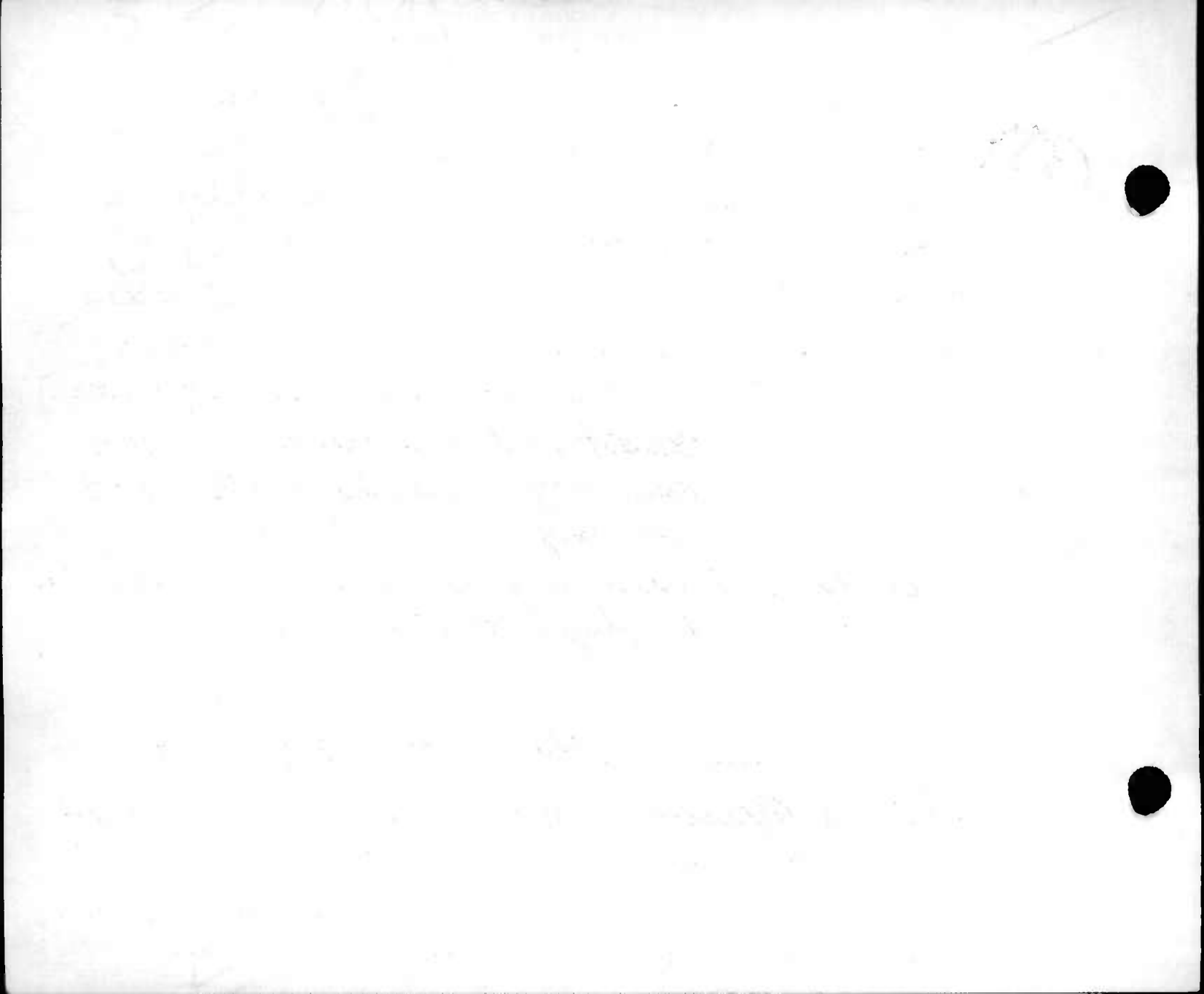
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Katie</b>  |  |  | 4. RACE<br><b>WHITE</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 7, 1921</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JULY 25, 1984</b>   |  |  | 2b. HOUR<br><b>8:09 a.m.</b>                                      |  |  |
| 1. SEX<br><b>FEMALE</b>   |  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. VA.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |  |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>63</b> YRS.   |  |  | # UNDER 1 YEAR<br>MONTHS DAYS                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSP.</b> |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                     |  |  |
| 13a. STATE<br><b>MD.</b>  |  |  | 13b. COUNTY<br><b>BALTO</b>   |  |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8153 PARKHAVEN RD. 21222</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PETE PAPPAS</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ARGETTA</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>235-16-0964</b>   |  |  | 17. INFORMANT ADDRESS<br><b>ARGETTA SHUPE 8153 PARKHAVEN RD.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE STROKE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |  |
| 22. I certify that (this hospital) attended the deceased from <b>JULY 18, 1984</b> to <b>JULY 25, 1984</b> , that (we) lost above <b>JULY 25, 1984</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated.  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 27a. SIGNATURE<br><i>[Signature]</i>  |  |  | DEGREE<br><b>M.D.</b>   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  | 27c. DATE SIGNED<br><b>JULY 25, 1984</b>   |  |  |   |  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. VILLALOBOS, M.D.</b>   |  |  | 27e. ADDRESS<br><b>9000 FRANKLIN SQUARE DR., 21237</b>  |  |  |   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>7/27/84</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEK CEM.</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD.</b>   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>CONNELLY FUNERAL HOME OF DUNDALK</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 31 1984</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |  |  |   |  |  |

BP



RECEIVED  
JUL 31 1964

12

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18152

|  |   |   |   |   |                     |
|--|---|---|---|---|---------------------|
| 1- FOR STATE REGISTRAR   |   | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR  |                     |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | 2c. DATE PRONOUNCED DEAD  |   | 2d. HOUR  |                     |
| Marjorie Anne Lawrence   |   | 7 319 84  |   | 10:38 PM  |                     |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | 7. IF UNDER 1 YR.   | 8. IF UNDER 24 HRS. |
| Female   | White   | July 28, 1927   | 56 YRS.   |   |                     |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 9b. CITIZEN OF WHAT COUNTRY?  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH   |                     |
| Illinois   | U.S.A.  |   |   | Baltimore County, MD  |                     |
| 12. CITY OR TOWN OF DEATH  | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 15. KIND OF BUSINESS OR INDUSTRY  |                     |
| Reisterstown   | 27 Chestnut Hill Lane   | Sales Clerk   |   | Various Shops   |                     |
| 16a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 16b. STATE  | 16c. COUNTY   | 16d. CITY OR TOWN   | 16e. INSIDE CITY LIMITS?  | 16f. STREET ADDRESS |
| Maryland   | Baltimore   | Reisterstown  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 27 Chestnut Hill Lane 21136   |                     |
| 17. FATHER'S NAME  | 18. MOTHER'S MAIDEN NAME  | 19. ADDRESS   |   |   |                     |
| Harold F. Scovel   | Marjorie Mereness   | 4608 Calvert Road   |   |   |                     |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  | 21. SOCIAL SECURITY NO.   | 22. INFORMANT   |   |   |                     |
| No   | 345 22 6180   | Mrs. Martha E. Lawrence College Park, Md.   |   |   |                     |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |   |   |   |                     |
| PART I DEATH WAS CAUSED BY:  |   |   |   |   |                     |
| IMMEDIATE CAUSE (a) Smoke and soot inhalation  |   |   |   |   |                     |
| 8902   |   |   |   |   |                     |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |   |                     |
| (b) _____  |   |   |   |   |                     |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |   |                     |
| (c) _____  |   |   |   |   |                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |   |   |   |   |                     |
| 24a. DATE OF OPERATION   |   | 24b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 24c. AUTOPSY?   |                     |
|  |   |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                     |
| 25a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 25b. TIME OF INJURY   |   | 25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                     |
|  |   | 1022 P.M. 7 3 19 84   |   | House fire  |                     |
| 26a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |   | 26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 26c. LOCATION   |                     |
|  |   | home  |   | 27 Chestnut Hill Lane, Reisterstown, Balto, Md.                               |                     |
| 27. I certify that I took charge of the remains described above, held on _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from _____ Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |   |   |   |   |                     |
| ACTUAL SIGNATURE   |   | TITLE (SPECIFY)   |   | DATE SIGNED   |                     |
| Thomas D. Smith, M.D.  |   | Deputy Chief, MEDICAL EXAMINER  |   | 7/4/84  |                     |
| EXAMINER'S NAME (TYPE OR PRINT)  |   | ADDRESS   |   |   |                     |
|  |   | 111 Penn St. Balto., MD.  |   |   |                     |
| 28a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 28b. DATE   | 28c. NAME OF CEMETERY OR CREMATORY  | 28d. LOCATION CITY OR TOWN  | 28e. COUNTY   | 28f. STATE          |
| Cremation  | July 6, 1984  | Metropolitan Crematory  | Alexandria  | N/A   | Virginia            |
| 29. FUNERAL DIRECTOR NAME  |   | 29a. DATE REC'D. BY REGISTRAR   |   | 29b. REGISTRAR'S SIGNATURE  |                     |
| F. Gasch's Sons F.H. P.A. Hyatts. Md. 20781  |   | JUL 11 1984   |   | John Davidson-Randall   |                     |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



Form 100, July 2, 1957

U.S.A.

Various Shore

Various Hill Land

Various

Various

Various

Various

Various

Various

Various

Various

Various

Various

Various

Various

Various

Various

Various

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 4 1 8 1 5 3

FOR  
 STATE  
 REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LULA (LUELLA) G. LAYMAN   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 22 84                           |   | 2b. HOUR<br>10:30 P.M.   |
| 3. SEX<br>Female   | 4. RACE<br>CAUCASIAN  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 14 03  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>PA.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO/COUNTY MD   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St Joseph's Hos 6700 York Rd |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maid | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sheppard Pratt   |  |
| 13a. STATE<br>MD   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>-----   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ray Shaffer  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lena   |  | 13e. STREET ADDRESS / ZIP CODE<br>6713 YORK Rd Apt 2 / 21212                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>216-34-7543   |  | 17. INFORMANT<br>ADDRESS<br>Meylert Layman 6713 York Rd. Bal. Md. 21212                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Anterior Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary Vascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 months   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-13-</u> , 19 <u>84</u> , to <u>7-22</u> , 19 <u>84</u> , that (I) <del>was</del> lost<br>saw the deceased alive on <u>7-22-</u> 19 <u>84</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>was</del> (did) <del>not</del> view the body after death.         |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Bernard S. Karpers</u>  |   | DEGREE<br><u>M.D.</u>   |  | 22c. DATE SIGNED<br><u>7-23-84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>BERNARD S. KARPERS JR. M.D.</u>  |   | 22e. ADDRESS<br><u>107 PROFESSIONAL PARK AVE. BALTO. MD 21201</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>July 26, 1984  | 23c. NAME OF CEMETERY OR CREMATORY<br>Terrytown Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Terrytown Bradford Co. Pa.                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home  |   | ADDRESS<br>6500 York Rd. Bal. Md. 21212   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 24 1984  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED  
JUL 11 1964

11

THE  
UNITED STATES  
DEPARTMENT OF  
THE ARMY  
WASHINGTON, D.C. 20315

TO: THE SECRETARY OF THE ARMY  
FROM: THE CHIEF OF STAFF  
SUBJECT: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]

11. [illegible]  
12. [illegible]  
13. [illegible]  
14. [illegible]  
15. [illegible]  
16. [illegible]  
17. [illegible]  
18. [illegible]  
19. [illegible]  
20. [illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 5 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                             |  |
|--|--|--|--|---|-----------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>William LEACH</b><br><i>William R. Leach, Sr.</i>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 25, 1984</b> |   | 2b HOUR<br><b>10:45p.m.</b> |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 3 1900</b>                             |                             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>84</b><br>YRS MONTHS DAYS HOURS MIN.         |                             |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Sq. Hospital</b>            |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |                             |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Shipyard</b>  |  | 13a STREET ADDRESS & ZIP CODE<br><b>5 Brett Court 21221</b>                         |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>    |                             |  |
| 16b SOCIAL SECURITY NO.<br><b>212 14 9191</b>  |  | 17 INFORMANT<br><b>Wm. R. Leach, Jr.</b>   |  | 18 ADDRESS<br><b>430 Cedar Spring Rd.<br/>Belair, Md. 21004</b>                     |                             |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Aspiration of gastric contents</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Coronary Artery Disease; Chronic Pulmonary Disease</b>  |  |  |  |   |                             |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                             |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |                             |  |
| 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |                             |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                             |  |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 25</b> , 19 <b>84</b> , to <b>July 25</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.   |  |  |  |   |                             |  |
| 22b SIGNATURE<br><i>Susan Z. W. Krasner</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>7/26/84</b>   |                             |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Susan Z. W. Krasner</b>   |  | 22e ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |  |   |                             |  |
| 23a BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b DATE<br><b>7/28/84</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Pk.</b>                  |                             |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Carroll Co., Md.</b>   |  | 24 FUNERAL DIRECTOR<br><b>Brazdzinski Funeral Home PA</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 27 1984</b>                                  |                             |  |
| 25b REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rodella</i>   |  | 26 OLD EASTERN AVE<br><b>1407 Old Eastern Ave</b>  |  |   |                             |  |

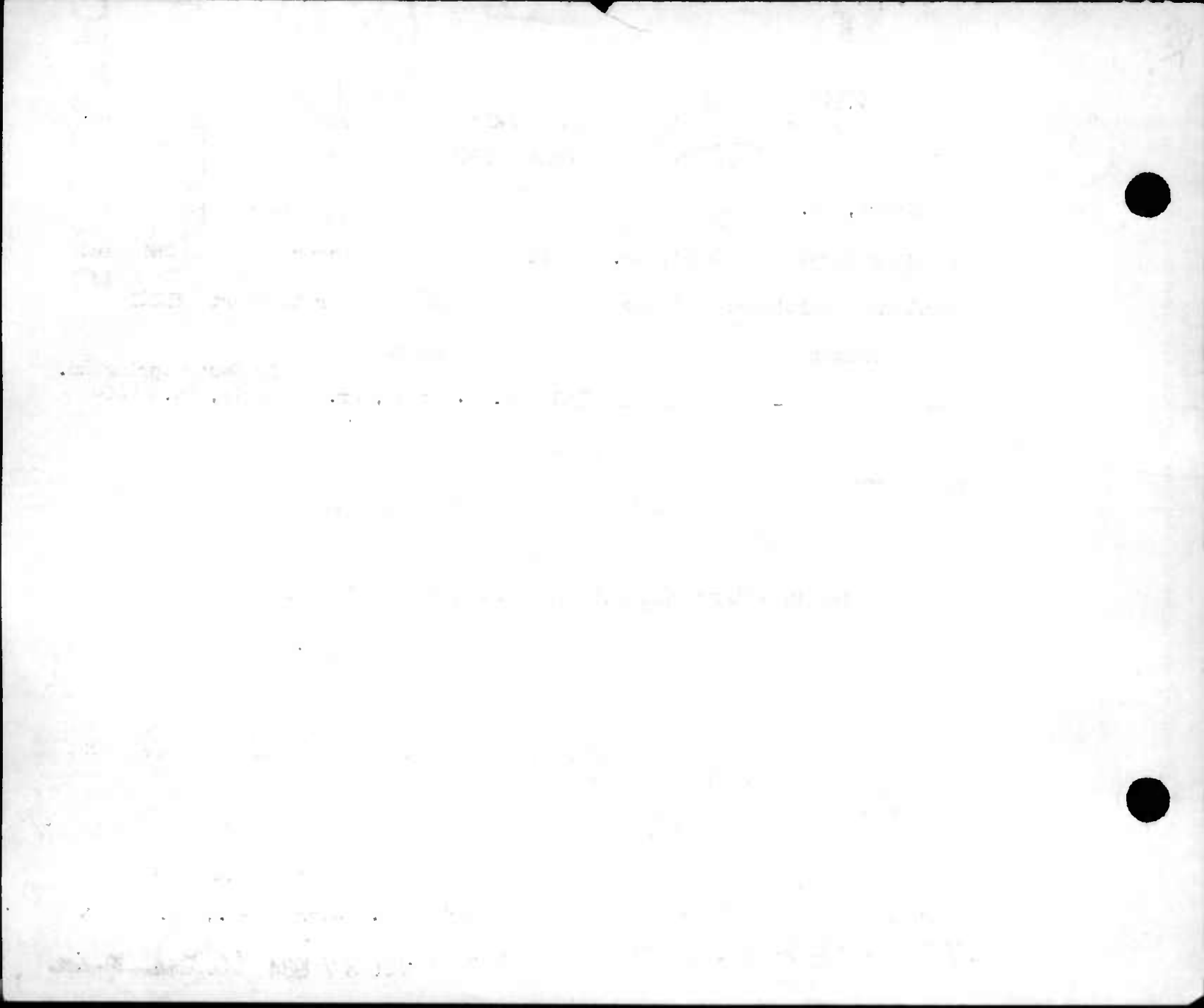
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |   |                   |   |                        |   |  |  |  |
|---|---------|---|-------------------|---|------------------------|---|--|--|--|
| 1- STATE REGISTRAR  |         | 20. DATE KNOWN OF DEATH   |                   | 21. DATE PRONOUNCED DEAD  |                        | 22. DATE REC'D. BY REGISTRAR  |  | 23. REGISTRAR'S SIGNATURE                    |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | 20. DATE KNOWN OF DEATH   |                   | 21. DATE PRONOUNCED DEAD  |                        | 22. DATE REC'D. BY REGISTRAR  |  | 23. REGISTRAR'S SIGNATURE                    |  |
| HARRY N LEMONS  |         | MONTH DAY YEAR 19 84  |                   | MONTH DAY YEAR 19 84  |                        | MONTH DAY YEAR 19 84  |  | JULY 24, 1984                                |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | IF UNDER 1 YR.  | IF UNDER 24 HRS.       | 8. MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |
| M   | W       | 7 3 19  | 65 YRS.           | MONTHS DAYS HOURS MIN.  | MONTHS DAYS HOURS MIN. | X NEVER MARRIED   |  | Baltimore County MD                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                 |         | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED  |                        | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | 10. CITY OR TOWN OF DEATH                    |  |
| North Carolina  |         | USA   |                   | WIDOWED   |                        | Baltimore County  |  | Rossville                                    |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                  |         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                        | 13a. STATE  |  | 13b. COUNTY                                  |  |
| Franklin Square Hospital  |         | Operator  |                   | MTA   |                        | Maryland  |  | Baltimore                                    |  |
| 13c. CITY OR TOWN   |         | 13d. INSIDE CITY LIMITS?  |                   | 13e. STREET ADDRESS   |                        | 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                     |  |
| 6 Lark Meadow Ct. 21236   |         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   | 6 Lark Meadow Ct. 21236   |                        | James Milton  |  | Lenora Bevill                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                              |         | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT   |                        | 18. CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Yes   |         | 131-07-1675   |                   | G. Elaine Lemons 6 Lark Meadow Ct. 21236                            |                        | PART I DEATH WAS CAUSED BY:   |  |  |  |
| WW 11   |         |   |                   |   |                        | IMMEDIATE CAUSE (a)   |  |  |  |
|   |         |   |                   |   |                        | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
|   |         |   |                   |   |                        | (b)   |  |  |  |
|   |         |   |                   |   |                        | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
|   |         |   |                   |   |                        | (c)   |  |  |  |
|   |         |   |                   |   |                        | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |  |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |                   | 20. AUTOPSY?  |                        | 21a. EXTERNAL CAUSE WAS   |  | 21b. TIME OF INJURY                          |  |
|   |         |   |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        | UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | HOUR A.M. MONTH DAY YEAR                     |  |
|   |         |   |                   |   |                        |   |  | P.M. 19                                      |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY  |                   | 21f. LOCATION   |                        | 21g. LOCATION   |  | 21h. LOCATION                                |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>         |         | STREET, FACTORY, FARM, ETC.)  |                   | STREET  |                        | CITY OR TOWN  |  | COUNTY STATE                                 |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>         |         |   |                   |   |                        |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on |         | Autopsy <input type="checkbox"/>                                    |                   | Inspection <input checked="" type="checkbox"/>                      |                        | Inquiry <input type="checkbox"/>  |  | and in my opinion                            |  |
| death resulted from   |         | Natural causes <input checked="" type="checkbox"/>                  |                   | Accident <input type="checkbox"/>                                   |                        | Suicide <input type="checkbox"/>  |  | Homicide <input type="checkbox"/>            |  |
|   |         |   |                   |   |                        |   |  | Undetermined manner <input type="checkbox"/> |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)   |                   | DATE SIGNED   |                        | 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE                                    |  |
| PAUL F GUERIN   |         | DEPUTY MEDICAL EXAMINER   |                   | JULY 24, 1984   |                        | Burial  |  | 7-27-84                                      |  |
| EXAMINER'S NAME   |         | ADDRESS   |                   | 23c. NAME OF CEMETERY OR CREMATORY                                  |                        | 23d. LOCATION   |  | 23e. COUNTY                                  |  |
| PAUL F GUERIN   |         | 1311 WESTERN AVE  |                   | Dulaney Valley M.G.   |                        | CITY OR TOWN  |  | Baltimore, Maryland                          |  |
|   |         |   |                   |   |                        |   |  |  |  |
| 24. FUNERAL DIRECTOR  |         | 25. DATE REC'D. BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE  |                        | 25c. DATE REC'D. BY REGISTRAR   |  | 25d. REGISTRAR'S SIGNATURE                   |  |
| LASSMAN FUNERAL HOME  |         | BALTO. MD 7-27-84   |                   | Julia Swanson   |                        |   |  |  |  |

100-100000

REBILITATION

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8 4 1 8 1 5 6 |  |
|---|--|--|--|---|--|---|--|--|--|---------------|--|
| 1 - FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DONALD LEVY</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7/27/84</b>   |  | 2b. HOUR<br><b>5:15P<sub>M</sub></b>   |  |               |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 5, 1924</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N CHARLES ST</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PATENT EXAMINER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. PATENT OFF.</b>   |  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>FLORIDA</b>  |  | 13b. COUNTY<br><b>CLEARWATER</b>   |  | 13c. CITY OR TOWN<br><b>CLEARWATER</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1849B BOUGH AVE. 99949</b>  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH LEVY</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE GOLDBERG</b>   |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR SERVICE<br><b>YES WWII - ARMY</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><input checked="" type="checkbox"/>   |  | 17. INFORMANT<br>NAME ADDRESS<br><b>MR. MICHAEL LEVY #20910<br/>8811 COLESVILLE RD, APT 818 SILVER SPRING, MD</b>                         |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>AMYOTROPHIC LATERAL SCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PNEUMONIA</b> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 MIN</b><br><b>1 YEAR</b><br><b>5 DAYS</b>                            |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 23 19 84</b> to <b>JULY 27 19 84</b> that (I) (we) last saw the deceased alive on <b>JULY 27 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><i>John E. Lobato</i>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7/27/84</b>   |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. E. LOBATO</b>   |  |  |  | 22e. ADDRESS<br><b>GBMC</b>   |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>7-29-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KNESSETH ISRAEL CONG.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNAPOLIS ANNE ARUNDEL MD</b>  |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD., BALTO., MD 21215</b>   |  |  |  |   |  | 25. DATE REC'D BY REGISTRAR<br><b>AUG 1 1984</b><br>REGISTRAR'S SIGNATURE<br><i>John E. Lobato</i>  |  |  |  |               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 11 shows any injury, or other traumatic event, the medical examiner must be notified.

1241

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18157

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Edward Carlyle Lewis</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 25, 1984</b>                                     |   | 2b. HOUR<br>M<br><b>AM</b>                                       |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 27 1921</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Dayton, Pa.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex 21221</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>802 Martin Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Welder</b>               |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing</b>             |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Baltimore Essex</b> |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David A. Lewis</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dora A. Bussard</b>                         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>171 12 9615</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Elizabeth O. Lewis, Wife</b> <b>Same</b> |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>2 yrs</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b> |
|---|--|---|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>April 55</b> 19 <b>55</b> to <b>July 84</b> 19 <b>84</b> , that (1) <b>not lost</b> saw the deceased alive on <b>June 84</b> 19 <b>84</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (1) <b>was</b> (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert Lyden, M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>7/27/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Lyden, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>6402 Golden Ring Rd. Balto Md. 21237</b>                    |  |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>                     | 23b. DATE<br><b>7/28/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Memorial Gardens</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Brudzinski Funeral Home PA 1407 Old Eastern Ave</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 27 1984</b>                      | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>              |

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03

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

18158

|   |  |   |   |  |                                      |  |
|---|--|---|---|--|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARTHA ELSIE LINDEMEYR</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-14-84</b>   |  | 2b. HOUR<br><b>5<sup>50</sup> AM</b> |  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-24-10</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS   |                                      |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                            |                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>OLD COURT NURSING CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESGIRL</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |                                      |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>REISTERSTOWN</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>314 ACADEMY AVE. 21136</b>                                |                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT ORR</b>                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARTHA BUCKEL</b>   |   |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>         |  | 16b. SOCIAL SECURITY NO.<br><b>218-14-5546</b>  |   | 17. INFORMANT<br>NAME ADDRESS<br><b>HERBERT LINDEMEYR 1941 EWARD AVE<br/>DUNDALK MD. 21222</b> |                                      |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Myocardial Infarction**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**18 MOS**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <b>84</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 12</b> 19 <b>83</b> , to <b>July 14</b> 19 <b>84</b> , that (I) (we) last<br>saw the deceased alive on <b>July 15</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Daniel Bakal MD</b>  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>July 16, 84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL BAKAL</b>  | 22e. ADDRESS<br><b>600 Reisterstown Rd. Balto. Md. 21208</b>   |  |   |

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> | 23b. DATE<br><b>July 17, 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PARK CEM.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WOODLAWN BALTIMORE MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>R. Larry Hightower</b>     |                                   | 25. DATE REC'D. BY REGISTRAR<br><b>JUL 17 1984</b>              |   |
| 25a. REGISTRAR'S SIGNATURE<br><b>John E. Hightower</b>        |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John E. Hightower</b>          |   |

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46-47-48

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61-62-63

64-65-66

67-68-69

70-71-72

73-74-75

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                        |  |                                    | 8 4 1 8 1 5 9   |  |  |  |
|--|------------------------|--|------------------------------------|---|--|--|--|
| 1 - STATE REGISTRAR  |                        |  |                                    | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IRVING H. LISANSKY</b>  |                        |  |                                    | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>4</b> YEAR <b>84</b>   |  | 2b. HOUR<br><b>2:30</b> P.M.   |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>CAUC</b> | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>28</b> YEAR <b>21</b>   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY - MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA MARIS HOSPICE</b> |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>  |  |
| 13a. STATE<br><b>Md.</b>   |                        | 13b. COUNTY<br><b>BALTO.</b>   | 13c. CITY OR TOWN<br><b>Balto.</b> | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>332 Stevenson Lane 21204</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>David</b> MIDDLE <b>Lisansky</b> LAST <b>Lisansky</b>  |                        | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Esther</b> MIDDLE <b>Keller</b> LAST <b>Keller</b>  |                                    |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |                        | 16b. SOCIAL SECURITY NO.<br><b>219-10-3528</b>   |                                    | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Ruth Lisansky - Same as #13</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LUNG CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.              |                        |  |                                    |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |                        |  |                                    |   |  |  |  |
| 19a. DATE OF OPERATION   |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6.23</b> , 19 <b>84</b> , to <b>7.4</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7.3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                        |  |                                    |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Faulkner MD</b>   |                        | DEGREE   |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Faulkner MD</b>  |                        | 22e. ADDRESS<br><b>2300 DULANEY VALLEY RD.</b>   |                                    |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |                        | 23b. DATE<br><b>7/4/84</b>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>B Anatomy Board</b> ADDRESS <b>Balto., Md.</b>   |                        |  |                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 6 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

20

Item #23b film #G594

FOR 8/9/84 jp

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 6 0

REG. NO.

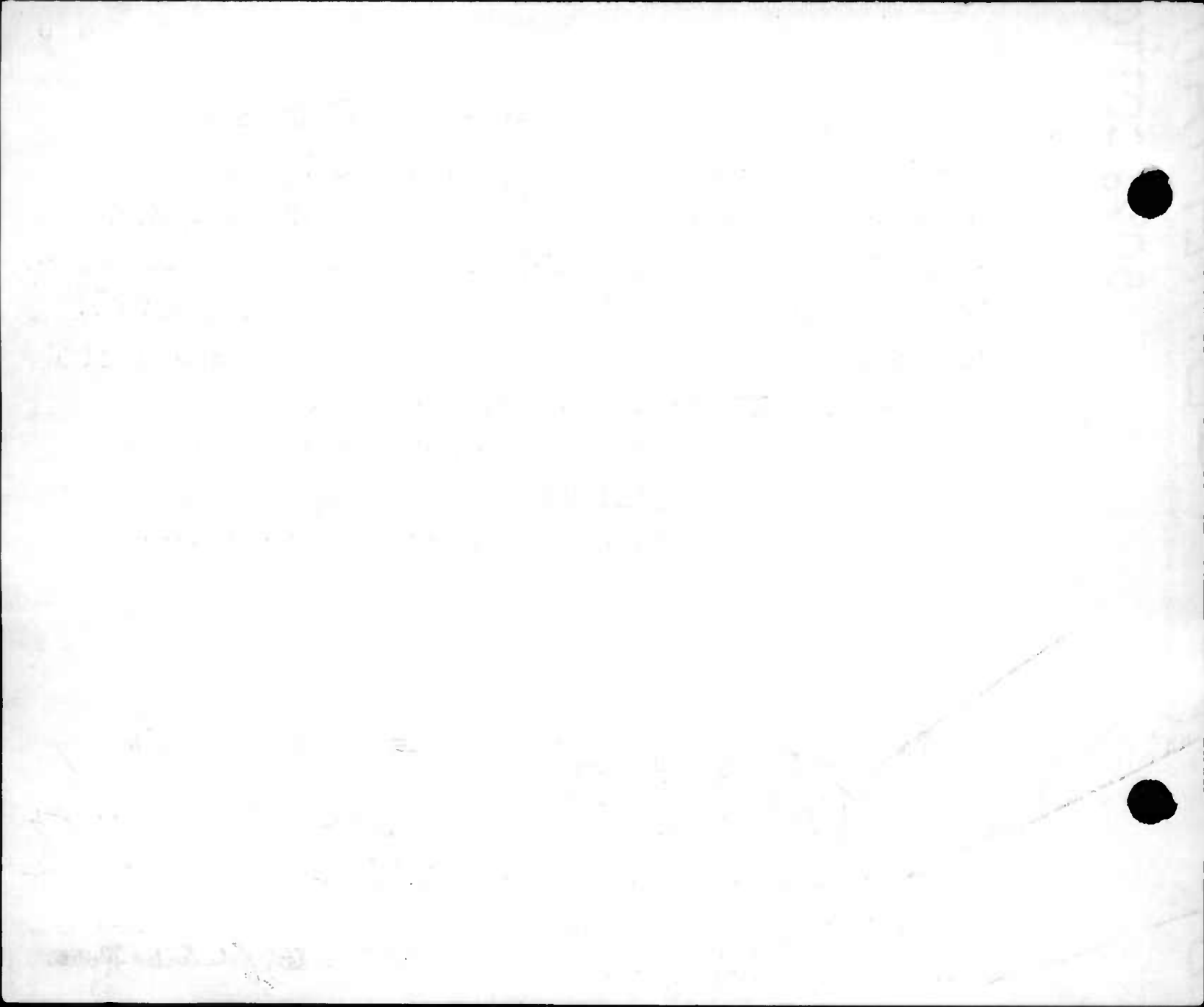
|  |  |   |   |   |  |  |   |  |  |                               |   |  |
|--|--|---|---|---|--|--|---|--|--|-------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>HARRY L. LITAKER  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>JULY 13 1984                                      |   | 2b. HOUR<br>M  |  |   |  |  |                               |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCT 1, 1926   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |  | IF UNDER 24 HRS<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |   |  |  |                               |   |  |
| 10. CITY OR TOWN OF DEATH<br>PARKVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3420 GLASSBORO DRIVE |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALES  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>DEPT. STORES                |  |                               |   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |   | 13c. CITY OR TOWN<br>PARKVILLE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br>3420 GLASSBORO DRIVE 21234     |  |                               |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LSS ROY LITAKER  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>WILMA BLACKBURN                      |   |  |  |   |  |  |                               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.II 229 22 2556         |   |  | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS   |   |  |  |                               |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CHRONIC MYOCARDIAL ISCHEMIA YES<br>DUE TO, OR AS A CONSEQUENCE OF (b) YES<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) REMOTE MYOC. INFARCTION |  |   |   |   |  |  |   |  |  |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YES |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |   |  |  |   |  |  |                               |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                               |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                            |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |                               |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>FEB 25 1984 |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>75 JUL 84   |   |  |  |                               |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from above; (1) (myself) (did not) attend the deceased after death.  |  |   |   |   |  |  |   |  |  |                               |   |  |
| 22b. SIGNATURE<br>DR. RICHARD D. BIGGS, JR.  |  |   |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>7-16-84                                      |  |                               |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. RICHARD D. BIGGS, JR.   |  |   |   |   |  | 22e. ADDRESS<br>7600 OSLER DRIVE - Towson 21204  |   |  |  |                               |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  |   | 23b. DATE<br>7/17/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT                              |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |  |                               |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANSCHAP22 OF MEMORIALS HARFORD ROAD  |  |   |   |   |  | ADDRESS<br>8800  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 20 1984                     |  |                               |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and certified in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 6 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |  |
|---|---|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Anna R Liza Kowska</i>  |   |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><i>July 18 1984</i>  |  | 2b HOUR<br>MIN<br><i>9:25<sup>AM</sup></i>                     |  |
| 3 SEX<br><i>Female</i>  | 4 RACE<br><i>W</i>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 7 02</i>                           |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>81</i>  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> |  |
| 10 CITY OR TOWN OF DEATH<br><i>Towson</i>   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>St. Joseph H Hosp.</i> |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Shoe</i>                 |  |  |
| 13a STATE<br><i>Maryland</i>  |   | 13b COUNTY<br><i>-</i>  | 13c CITY OR TOWN<br><i>Baltimore</i>   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Joseph - Lysakovski</i>   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Louise - Stoly</i>         |  | 13e STREET ADDRESS / ZIP CODE<br><i>239 N. Lugene Ave 21224</i>                                |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>216-09-2699A</i> |  | 17 INFORMANT ADDRESS   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Brain Stem Hemorrhage</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |  |  |  |
| 19a DATE OF OPERATION   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                     |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)          |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a I certify that (this hospital) attended the deceased from <i>7/17</i> , 19 <i>84</i> , to <i>7/18</i> , 19 <i>84</i> , that (we) lost saw the deceased alive on <i>7/18</i> , 19 <i>84</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If yes, I did) (do not) view the body after death.        |   |   |  |  |  |  |
| 22b SIGNATURE<br><i>Lester A. Wall Jr M.D.</i>  |   | DEGREE  |  | 22c DATE SIGNED<br><i>7/18/84</i>  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>LESTER A WALL JR M.D.</i>  |   | 22e ADDRESS<br><i>7620 York Rd Towson MD 21204</i>                            |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><i>Burial</i>  |   | 23b DATE<br><i>7-21-84</i>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer</i>                                      |  |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore - Md.</i>   |   | 23e DATE REC'D. BY REGISTRAR<br><i>JUL 20 1984</i>                            |  | 23f REGISTRAR'S SIGNATURE<br><i>John A. Moran</i>  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>John A. Moran, Inc. - 3000 E. Balto. St.</i>  |   | 25a DATE REC'D. BY REGISTRAR<br><i>JUL 20 1984</i>                            |  |  |  |  |

BP

The following is a list of the names of the persons who have been  
 named in the report of the Committee on the subject of the  
 proposed amendment to the Constitution of the State of New York.  
 The names are given in the order in which they were named.  
 The names of the persons who have been named in the report of the  
 Committee on the subject of the proposed amendment to the  
 Constitution of the State of New York are given in the order in  
 which they were named.

RECEIVED  
 JAN 1 1888

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4

1 8 1 6 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ESTELLE</b><br><b>ESTELLE</b>   |  | FIRST<br><b>M.</b>  |  | MIDDLE<br><b>LLOYD</b>  |  | LAST<br><b>LLOYD</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 / 8 / 84</b>   |  | 2b. HOUR<br><b>4:35 AM</b>                                   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 30, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>YRS.</b>                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>/X/ U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD</b>                             |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>         |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>302 E. Joppa Road 21204</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard W. Shield</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Charlotte S. Stewart</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(# YES, GIVE WAR OR DATES)<br><b>197-10-3882D<br/>228-05-7645</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mary Lynne Lloyd, Same AS #13e 21204</b>   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (1) (the hospital) attended the deceased from <b>7-6</b> 19 <b>84</b> to <b>7-8</b> 19 <b>84</b> , that (1) (we) lost <b>7-8</b> 19 <b>84</b> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above.   |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert E. Stoner</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>7-8 84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert E. Stoner</b>  |  |   |  | 22e. ADDRESS<br><b>714 York St. 21204</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>7-9-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 11 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ch. Davidson-Randall</b>                                       |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical certificate must be completed by a physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 6 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

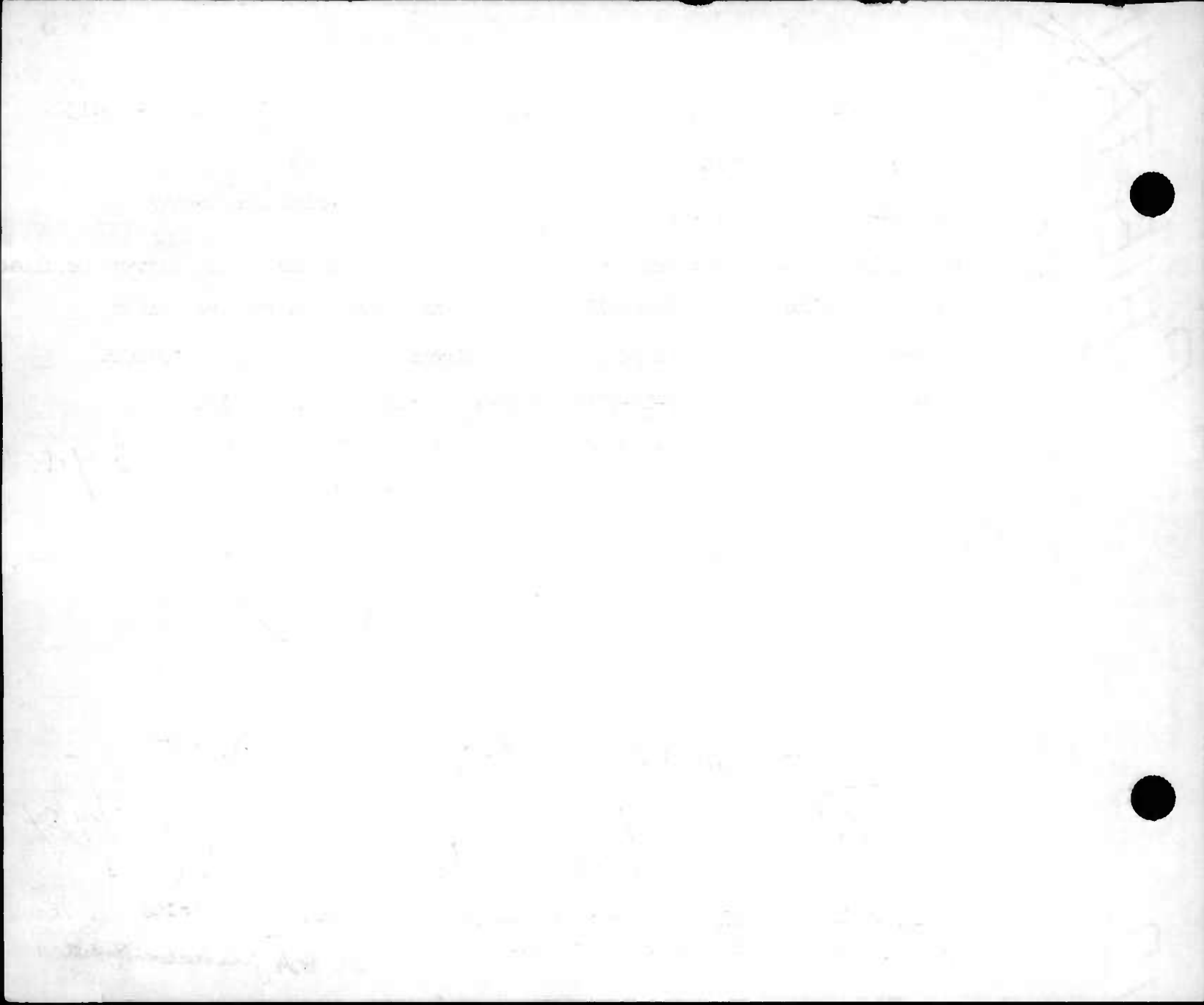
|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>John Thomas Lloyd   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 18 84                               |   | 2b. HOUR<br>9:15AM   |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 15 1899   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>402 Montemar Ave |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer | 12b. KIND OF BUSINESS OR INDUSTRY<br>Western Railroad   |  |
| 13a. STATE<br>Md  |   | 13b. COUNTY<br>Balto  | 13c. CITY OR TOWN<br>Catonsville   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>402 Montemar Ave 21228   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Lloyd  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bircha Kennett   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>705-10-7746   |  | 17. INFORMANT<br>ADDRESS<br>Berchie Manley Same as 13e  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma prostate with metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 yrs. |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) (the hospital) attended the deceased from 7/16/84 to 7/18/84, that (1) (same) last saw the deceased alive on 7/18/84, and that in my (my) opinion death occurred on the date and hour and from the causes stated above. (If (a) (b) (c) not view the body after death.  |   |   |  |   |  |
| 22b. SIGNATURE<br>W E Mc Gath MD  |   | 22c. ADDRESS<br>1303 Frederick Catonsville 21228 MD   |  | 22d. DATE SIGNED<br>7/19/84   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W E Mc Gath MD   |   | 22f. ADDRESS<br>1303 Frederick Catonsville 21228 MD   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>7/21/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem Gdns                |   | 23d. LOCATION<br>Timonium Balto MD   |
| 24. FUNERAL DIRECTOR<br>George J. Gonce   |   | 4001 Ritchie Hwy Balto Md   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 20 1984  |  |
|   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 6 4

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |   | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>KATHERINE (KATHARINA) A. LOBIG</b>   |   | 7-13-84   |  | 5:56 <sup>M</sup>   |  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-10-95</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY- MD.</b>                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b> |
| 13a. STATE<br><b>MD.</b>  |   | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>BALTO.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD YEAGER</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-74-5461</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. John O. Lobig - 7904 35<sup>TH</sup> ST. 21237</b>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hrs.</b> |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/25</b> 19 <b>82</b> , to <b>7-13</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>7/15/84</b> 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Darold K. Beard</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>7/13/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAROLD K. BEARD</b>   |   | 22e. ADDRESS<br><b>11 E Chestnut Hill LA.<br/>Rivertonstown, Md 21136</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>7-16-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE Cem.</b>                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO., MD.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 16 1984</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HARTLEY Miller Funeral Home</b>  |   | ADDRESS<br><b>7527 Hayfield Rd.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Rendall</b>   |  |

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UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C. 20315

MEMORANDUM FOR THE CHIEF OF STAFF

DATE: 10-10-52

BY: [Signature]

USA

Germany

Area

AMERICAN COMBAT CENTER

TO: [Signature]

FROM: [Signature]

NY

General Yenger

10-10-52

NY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |   |  | REG. NO. 84 18165  |  |  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>FRANCES LOEB</b>  |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>7/19/84</b>  |  |  |  | 2b HOUR<br><b>9:58P M</b>   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>SEPTEMBER 28, 1911</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ENGLAND</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>                              |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHABRES ST GBMC</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESPERSON</b>             |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>   |  |
| 13a STATE<br><b>FLORIDA</b>   |  | 13b COUNTY<br><b>PORT ST. LUCIE</b>   |  | 13c CITY OR TOWN<br><b>PORT ST. LUCIE</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br><b>6 HIDALCO LANE #33452 99999</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>MYER ABRAM</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>JANE PHILLIPS</b>   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b SOCIAL SECURITY NO.<br><b>060-26-6573</b>   |  | 17. INFORMANT ADDRESS<br><b>WESTCHESTER RIVERSIDE MEMORIAL CHAPELS<br/>21 W. BROAD ST. MT. VERNON, N.Y. #10552</b>   |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>MULTIPLE MYELOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CHRONIC RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CONGESTIVE HEART FAILURE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>7/19 84</b> to <b>7/19 84</b> , that (I) (we) lost saw the deceased alive on <b>7/19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) remove the body after death.   |  |   |  |  |  |  |  |   |  |
| 22b SIGNATURE<br><i>Dr. H. Depamphilis</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c DATE SIGNED   |  |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR H. DEPAMPHILIS</b>  |  |   |  | 22f ADDRESS<br><b>GBMC</b>   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>REMOVAL-BURIAL</b>   |  | 23b DATE<br><b>7/22/84</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>SHARON GARDENS CEM</b>   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>VALHALLAH NEW YORK</b>                         |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS. INC.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>   |  |   |  | 25a DATE REC'D BY REGISTRAR<br><b>JUL 25 1984</b>  |  | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES ALBERT LONG</b><br><i>JAMES</i>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>4</b> YEAR <b>84</b><br><b>8<sup>30</sup> P M</b>   |   |  |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>April</b> DAY <b>2</b> YEAR <b>1903</b>   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b>8</b> DAYS <b>1</b>               |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, County</b> MD.                           |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Perring Parkway Nursing Home</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Buyer</b>                |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Wholesale</b>           |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>Maryland</b> 13b COUNTY <b>Baltimore</b> 13c CITY OR TOWN <b>Essex</b>  |  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br><b>William Thomas Long</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Mary Lucinda Harris</b>   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>217-01-3090</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Shirley Stalcup 6 Thurmont Ct. 21236</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>                                    |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5-31-84</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Peripheral Vascular Dis. Bilateral A-K Amputations</b>   |  |  |  |   |  |
| 19a DATE OF OPERATION<br><b>?</b>   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>P. V. D</b>  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f LOCATION<br>STREET <b>4/13/81</b> CITY OR TOWN <b>7/4/84</b> COUNTY STATE  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>7/4/84</b> to <b>7/4/84</b> , that (I) (we) last saw the deceased alive on <b>7/4/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b SIGNATURE<br><b>Anthony F. Carozza</b>  |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>7-5-84</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony F. Carozza</b>   |  | 22e ADDRESS<br><b>1801 Wentworth Rd Baltimore Md 21234</b>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b DATE<br><b>7-7-84</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |  | 23d LOCATION<br>CITY OR TOWN <b>Essex</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Road 21212</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 6 1984</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 6 7

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. Johnson Joseph Long</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 3 1984</b>   |  | 2b. HOUR<br>M<br><b></b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 16 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8040 Peach Bottom Lane</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Caretaker-Druoid</b>                                |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ridge/Louden Pk</b>  |  | 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8040 Peach Bottom Lane 21207</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b></b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b></b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-32-4392</b>   |  | 17. INTERVIEWED BY<br><b>Mr. and Mrs. Thomas Russell</b>  |  | 18. INTERVIEWED AT<br><b>8040 Peach Bottom Lane Baltimore Maryland</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Gastric Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>? 1 yr.</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>4/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gastric Carcinoma</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>4/ 19 84 July 3 84</b>  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>July 2 19 84</b> , and that in (my) <b>(own)</b> opinion death occurred on the date and hour and from the causes stated above, (1) <b>(we)</b> <del>which</del> <b>(did not)</b> view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Daniel Bakal</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>7.5.84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Daniel Bakal</b>   |  |  |  | 22e. ADDRESS<br><b>Reisterstown Roads and Slade Avenues 21208</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>07-06-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olive Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Baltimore Maryland</b>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, Maryland 21133</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>1111 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>G. Davidson Randall</b>   |  |

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

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1- FOR  
STATE  
REGISTRAR

REG. NO.

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|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>INNOCENTA J. LO PRESTI</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 1, 1984</b>                                      |  | 2b. HOUR<br>M<br><b></b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 30, 1914</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1202 Dulaney Valley Rd.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Towson</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1202 Dulaney Valley Rd. 21204</b>               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Guarino</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Caroline Ferrera</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-74-4733</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Carmelo J. LoPresti - Same as #13e</b>                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCVD</b>   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>± 5 yrs.</b>   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>renal failure</b>   |   |   |   |  | <b>1 yr.</b>   |
| (c) <b>diabetes mellitus</b>   |   |   |   |  | <b>10 yrs</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>81</b> , to <b>July</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>June 29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Edward P. Costlow</b> M.D.  |   |   |   | 22c. DATE SIGNED<br><b>7/2/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edward Costlow, M.D.</b>   |   |   |   | 22e. ADDRESS<br><b>3501 St. Paul Street</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>7-5-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1984</b>  |  |  |
|  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>IDA N LOWER</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 30 84</b>   |  | 2b. HOUR<br><b>9:30 AM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 16 17</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b><br>YRS. MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>DALT COUNTY MD.</b>                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOLSON</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK, LAST MOST OF WORKING LIFE)<br><b>RETIRED</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>                             |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY<br><b>BATZ</b>  | 13c. CITY OR TOWN<br><b>LUTHERVILLE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS ZIP CODE<br><b>59 Belmar RD 21093</b>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HAYDON LOWER</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA N. BRIGHT</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>218-18-5434</b>  |   | 17. INFORMANT<br><b>FAMILY RECORDS</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY INSUFFICIENCY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PURULENT PERICARDITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DPLA</b>  |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>① CEREBRAL INFARCTION ② PULMONARY ATELECTASIS AND BILATERAL HYDRATHORAX</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 19c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |   | DEGREE<br><b>S.M.D.</b>   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>REYNALDO ORJUELA-GOMEZ, M.D.</b>   |   | 22e. ADDRESS  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>JULY 3 1984</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OWENS VALLEY</b>                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>TIMONUM BALTO. MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPL OF MEMORIES HARFORD ROAD</b>  |   | ADDRESS<br><b>8800</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 11 1984</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                             |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8

REG. NO.

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|---|--|--|--|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MAMIE LOWERY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>07 19 '84</b>                |   | 2b. HOUR<br><b>11:54A M</b>                                  |  |   |  |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 20 1886</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88 92</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>SOUTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>   |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>                             |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>426 WINSTON AVE APT 7 21212</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CATOR BUCHANAN</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RACHEL UNKNOWN</b> |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>NO N/A</b> |   |  |  | 16b. SOCIAL SECURITY NO.<br><b>ODESSA ROBINSON BALTIMORE MD 21212</b> |  |
| 17. INFORMATION (DAUGHTER) 426 WINSTON AVE  |  |  |  |   |  |  |   |  |  | ADDRESS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MASSIVE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45 MINUTES</b>     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                 |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)      |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7/19</b> <b>84</b> to <b>7/19</b> <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/19</b> <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                      |  |  |  |   |  |  |   |  |  |   |  |
| 22a. SIGNATURE<br><b>Jay M. Lustbader, MD</b>   |  |  |  |   |  | DEGREE   |   |  | 22c. DATE SIGNED<br><b>7/19/84</b>                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAY M. LUSTBADER, M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>GBMC - 6701 N. CHARLES ST. 21204</b>  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>7/26/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETHEL CEMETERY</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ALEXANDRIA VA</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>PHILLIP BELL 311 N. PATRICK ST ALEX VA</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 31 1984</b>  |   |  |  |   |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |  |  |   |  |

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 4 1 8 1 7 1<br>REG. NO.  |  |  |  |                    |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>James Richard Lueders  |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 20 1984                                     |  |  |  | 2b. HOUR<br>4:30am |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Caucasian  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 10 1940  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                     |  |  |  |  |  |                    |  |
| 10 CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>17 Oella Avenue |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dock Foreman |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shipping  |  |  |  |                    |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN,<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>17 Oella Ave. 21228   |  |                    |  |
| 14. FATHER'S NAME<br>Charles H. Lueders Sr.  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Ottilia --- Leaf   |  |  |  |  |  |  |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A   |  |  |  | 16b. SOCIAL SECURITY NO.<br>220-36-0517  |  | 17 INFORMANT ADDRESS<br>Carol McNulty Same as #13e                               |  |  |  |  |  |                    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic Bronchitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |  |  |  |  |  |  |  |  |  |  |                    |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-14-84, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on 6-27-84, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |  |  |                    |  |
| 22b. SIGNATURE<br><u>[Signature]</u><br>DEGREE   |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sami A. Brahim, M.D.  |  |  |  |  |  | 22e. ADDRESS<br>7620 York Road Towson, Md. 21204                                 |  |  |  |  |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>7/23/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Johns Cem.                             |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Waterloo Md.   |  |                    |  |
| 24 FUNERAL DIRECTOR NAME<br>FLECK FUNERAL HOME, INC.<br>7061 Sandy Spring Rd. Laurel, Md.  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 24 1984                                     |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |  |  |  |                    |  |

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*Handwritten text, possibly a signature or name, appearing upside down.*

6-11-64

6-11-64

Samuel A. Graham, P.D.  
7120 Fox Road, Towson, Md. 21204

Samuel A. Graham, P.D.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

84-18172

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BERTHA LUKASIEWICZ</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 16 '84</b> |   |  | 2b. HOUR<br><b>4:07A</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 26 1914</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>69</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N. CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Cashier</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hotel</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1924 Bank St. 21231</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Panek</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine A. Krol</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-09-2677</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Vincent Lukasiewicz 1924 Bank St. 21231</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <b>SQUAMOUS CELL CA OF PHARYNX</b> |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6/20 19 84 to 7/16 19 84</b>  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/20 19 84</b> to <b>7/16 19 84</b> , that (I) (we) last saw the deceased alive on <b>7/16 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Mark McKenny</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>7/16/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK MCKENNY, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>July 19, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George A. Weber &amp; Sons Inc.</b>   |  |  |  | ADDRESS<br><b>705 S. Ann St.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 17 1984</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John A. Carson</i>  |  |  |  |   |  |   |  |  |  |

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MEDICAL CERTIFICATION

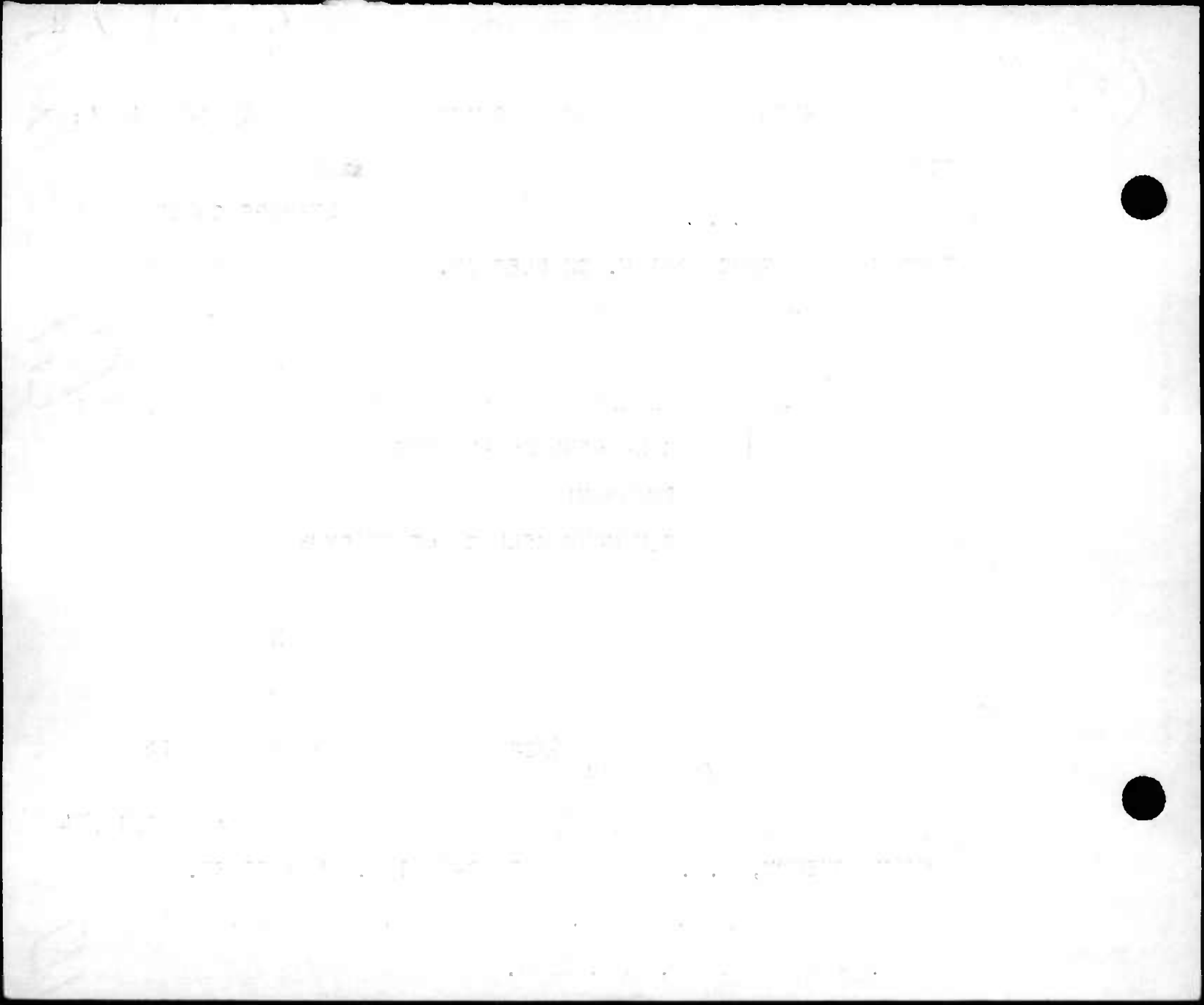
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18173

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |  |   |   |
|--|--|---|--|---|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James F. LYNCH  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 20, 1984  |   |  |  | 2b. HOUR<br>10:15a m  |   |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-4-1901   |   | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>82 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>—   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD  |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Essex   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electrician  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland   |  |   |  | 13c. COUNTY<br>—  |   | 13d. CITY OR TOWN<br>Baltimore   |  | 13e. STREET ADDRESS / ZIP CODE<br>101 N. Highland Avenue 21224  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph M. Lynch  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret — Ryan  |   |  |  | 16. ADDRESS<br>101 N. Highland  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>—   |   | 17. INFORMANT<br>Mrs. Sharon Czaplinski-Highland   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). PNEUMONIA COMPLICATED BY CONGESTIVE HEART<br>FAILURE WITH ACUTE RENAL FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b).<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c).                  |  |   |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DEHYDRATION   |  |   |  |   |   |  |  |   |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 14, 1984, to JULY 20, 1984, that (we) last saw the deceased alive on JULY 20, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |   |   |
| 22b. SIGNATURE<br>Doreen E. Feldhouse M.D.   |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>7-20-84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DOREEN FELDHOUSE M.D.   |  |   |  |   |   | 22e. ADDRESS<br>9000 FRANKLIN SQUARE DRIVE 21237   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>7-23-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dundalk - Balt Co. Md. |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>John A. Moran, Inc. - 3000 E. Balto Street   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 24 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |   |

MEDICAL CERTIFICATION

15

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 7 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                              |   |  |
|--|--|--|--|---|------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Ruby D. Lynn</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 16, 1984</b> |   | 2b. HOUR<br><b>2:05 P.M.</b> |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 12, 1900</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>84 years</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Old Court Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Woodlawn</b>  |                              | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Bell</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nettie Reed</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2012 Russell Avenue 21207</b>  |                              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-32-9448</b>   |  | 17. INFORMANT<br><b>Betty Reynolds</b>  |                              | ADDRESS<br><b>6516 Gilmore Street Woodlawn, MD 21207</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |   |                              |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>   |  |  |  |   |                              |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                              |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-1-83</b> , 19____, to <b>7-16-</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>July 6,</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |  |   |                              |   |  |
| 22b. SIGNATURE<br><i>Jerome H. Ginsburg</i>  |  |  |  | DEGREE<br><b>M.D.</b>   |                              | 22c. DATE SIGNED<br><b>7-16-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jerome H. Ginsburg</b>   |  |  |  | 22e. ADDRESS<br><b>5310 Old Court Rd. 21133</b>   |                              |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/19/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |                              | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Loring Byers Funeral Directors, Inc.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 18 1984</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><i>Carrollson-Robert</i>  |  |
| 8728 Liberty Rd. Randallstown, MD 21133  |  |  |  |   |                              |   |  |

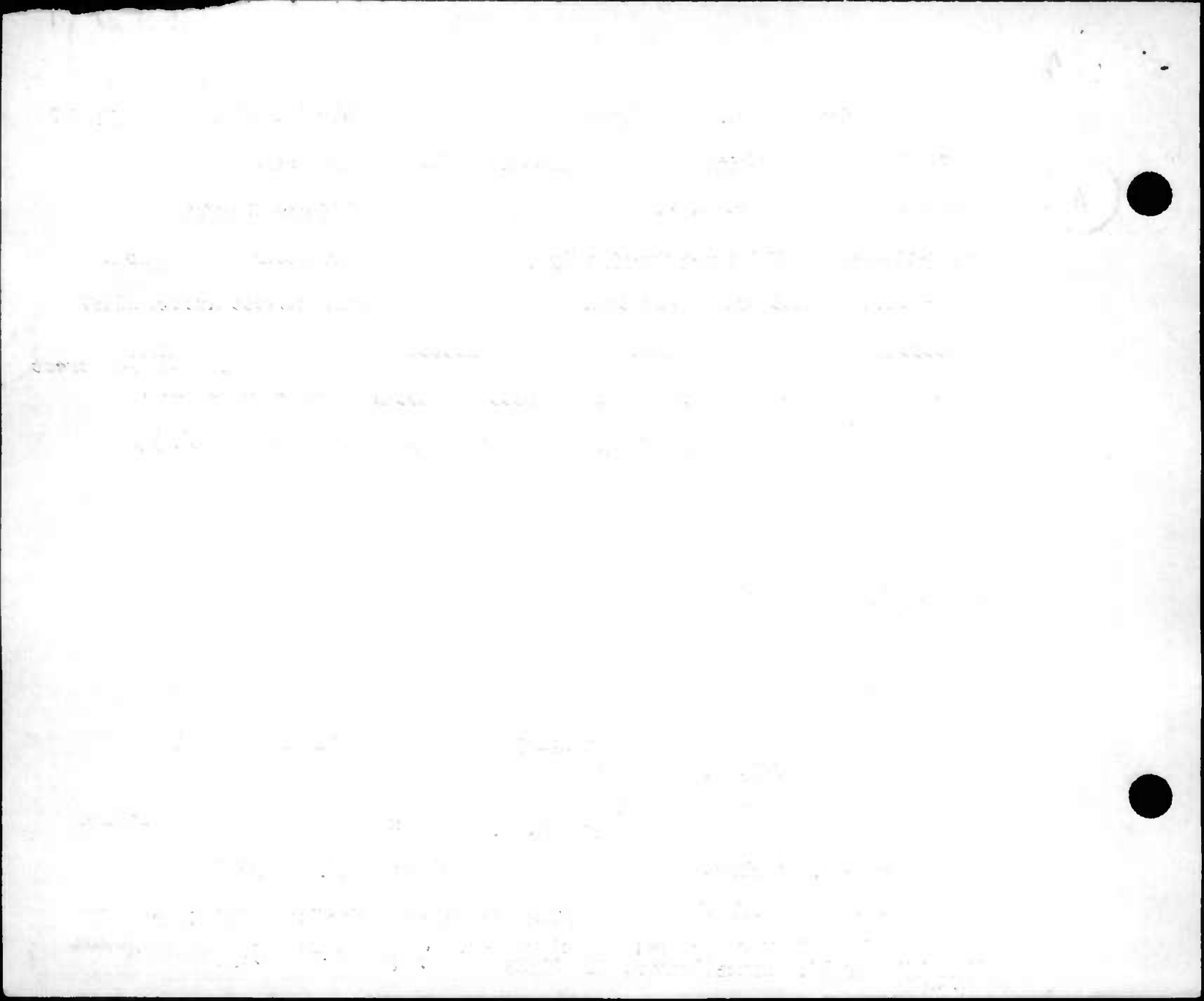
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 7 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |                         |  |  |   |                            |
|---|-------------------------|--|--|---|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EMMA ALVERDA MACLEOD</b> |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>07 13 84</b> |   | 2b. HOUR<br><b>7:45P M</b> |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 03 01</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS  |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                            |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FREDERICK VILLA NURSING CENTER</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |                            |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>    |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |   |                            |

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>                | 13c. CITY OR TOWN<br><b>LANDSOWNE</b>                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2218 SULPHUR SPRING ROAD, 21227</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES BRAUN</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA RITTERSHOFER</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>214-74-0601</b> |   | 17. INFORMANT<br>ADDRESS<br><b>JANIE M. OLVER 2614 WILLOW AVENUE, 21227</b>                     |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Septicemia*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) *UTI*

DUE TO, OR AS A CONSEQUENCE OF

(c) *ASCVD*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> 19 <u>84</u> to <u>July 13</u> 19 <u>84</u> that (I) (we) last<br>saw the deceased alive on <u>7/13</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><u><i>Elmo M. Gayoso</i></u>  |  |   |  | 22c. DATE SIGNED<br><u>7/16/84</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EILMO M. GAYOSO M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>5411 OLD FREDERICK ROAD, 21228</b>                          |   |

|   |  |                              |  |  |
|---|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>     |  | 23b. DATE<br><b>07-17-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b> |  |                              | ADDRESS<br><b>4107 WILKENS AVE.</b>                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 17 1984</b>                          |
| 25b. REGISTRAR'S SIGNATURE<br><u><i>John R. ...</i></u>           |  |                              |  |  |

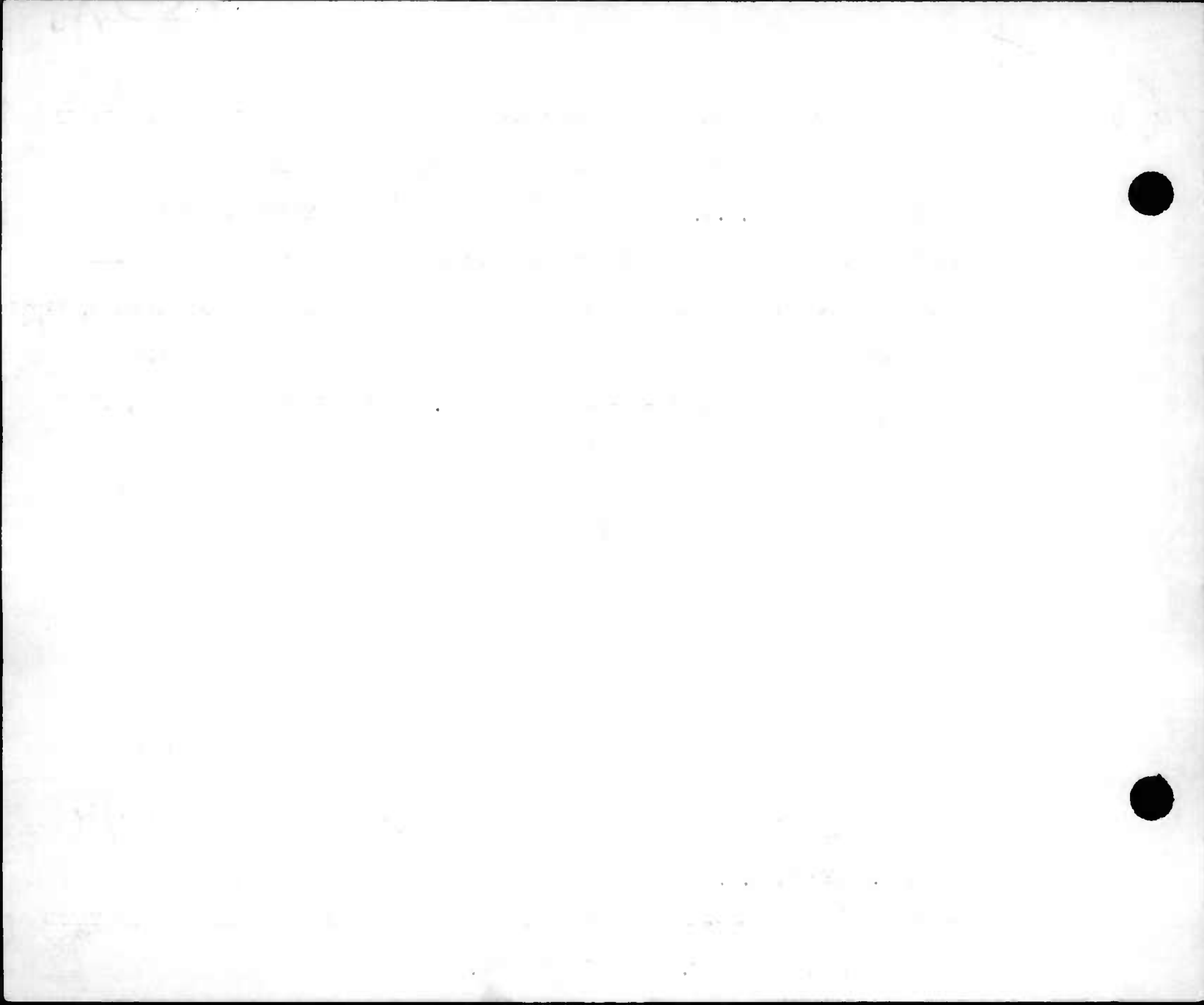
BP

B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



B6

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |                       |   |  |   |  |  |  |
|---|--|---|---|---|-----------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>John H Mahan  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07 04 84 |   | 2b. HOUR<br>9:15 A.M. |   |  |   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 17 12  |                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 7. IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                        |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nsg. Ctr.-Catonsville |   |   |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Executive, U.S. |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gov't  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Florida   |  |   |   | 13b. COUNTY<br>St. James City   |                       | 13c. CITY OR TOWN<br>St. James City   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>35 Dewberry Lane 99494   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wm/ Earl Mahan  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alva Shock   |                       |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   |   | 16b. SOCIAL SECURITY NO.<br>579-42-7354   |                       | 17. INFORMANT<br>ADDRESS<br>Mrs. C. Voy Mahan Same as above                         |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute MI, Hypertension, ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>nephrosclerosis Renal Vascular</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertension, CVA, Hypophyseal Syndrome, Hypothyroidism</u> |  |   |   |   |                       |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |   |   |   |                       |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)      |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> 19 <u>84</u> to <u>7/4</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>7/3</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |                       |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>John H. Shaw</u> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   |   |                       |   |  | 22c. DATE SIGNED<br>7/4/84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>John H. Shaw</u>  |  |   |   |   |                       |   |  | 22e. ADDRESS<br><u>5800 S. Emerson &amp; 30th Ave. Baltimore 21228</u>                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Cremation</u>  |  |   |   | 23b. DATE<br><u>July 6, 1984</u>  |                       | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Security Process Ctr.</u>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Catonsville, Balto. Co. Md.</u>                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</u>  |  |   |   |   |                       | 25a. DATE REC'D. BY REGISTRAR<br><u>1111 9 1984</u>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Richard Anderson</u>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DO NOT

RECEIVED

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |         |                  |   |                |  |  |  |                          |   |  |          |                                |  |  |
|--|---------|------------------|---|----------------|--|--|--|--------------------------|---|--|----------|--------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                  | FIRST MIDDLE LAST   |                |  | 2a. DATE KNOWN OF DEATH  |  |                          | MONTH DAY YEAR                            |  |          | 2b. HOUR                       |  |  |
| IDELLA T. MAJORS   |         |                  |   |                |  | July 13 1984   |  |                          | 7A  |  |          | M                              |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)   | IF UNDER 1 YR. |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD |   |  | 2d. HOUR |                                |  |  |
| Female   | White   | May 27, 1905     | 79 YRS.   |                |  |  |  | July 13 1984             |   |  | 7A       |                                |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH      |  |          | 10. CITY OR TOWN OF DEATH      |  |  |
| Pennsylvania   |         |                  | U.S.A.  |                |  |  |  |                          | Baltimore County                          |  |          | Towson                         |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |         |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                 |                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                          | 13a. STATE                                |  |          | 13b. COUNTY                    |  |  |
| 8422 Apt. B, Charles Valley Ct. Towson, Md. 21204  |         |                  | Homemaker   |                |  |  |  |                          | Pennsylvania                              |  |          | Beaver                         |  |  |
| 13c. CITY OR TOWN  |         |                  | 13d. INSIDE CITY LIMITS?  |                |  | 13e. STREET ADDRESS  |  |                          | 13f. ZIP CODE                             |  |          | 14. FATHER'S NAME              |  |  |
| Beaver Falls   |         |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |                |  | 3508 8th Ave., 15010   |  |                          | 99999                                     |  |          | Clyde Walker                   |  |  |
| 15. MOTHER'S MAIDEN NAME   |         |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |                |  | 16b. SOCIAL SECURITY NO.   |  |                          | 17. INFORMANT                             |  |          | 18. CAUSE OF DEATH             |  |  |
| Edna M. Zeigler  |         |                  | No  |                |  | 174-01-6297D   |  |                          | A.D. Campbell F.H. Inc. Beaver Falls, Pa. |  |          | 1326 8th Ave. 15010            |  |  |
| PART 1 DEATH WAS CAUSED BY:  |         |                  | IMMEDIATE CAUSE (a)   |                |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                          | DUE TO, OR AS A CONSEQUENCE OF            |  |          | DUE TO, OR AS A CONSEQUENCE OF |  |  |
|  |         |                  | Cardiac Respiratory Failure   |                |  | Metastatic Carcinoma of Kidney   |  |                          | Generalized Atherosclerosis               |  |          | Sudden                         |  |  |
|  |         |                  | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |                |  |  |  |                          |   |  |          | 1 ± yrs                        |  |  |
|  |         |                  |   |                |  |  |  |                          |   |  |          | 5 ± yrs                        |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |         |                  |   |                |  |  |  |                          |   |  |          |                                |  |  |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                |  |  |  |                          |   |  |          |                                |  |  |
|  |         |                  |   |                |  |  |  |                          |   |  |          |                                |  |  |
| 20. AUTOPSY?   |         |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |                |  |  |  |                          |   |  |          |                                |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY   |                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                          |   |  |          |                                |  |  |
|  |         |                  | P.M. 19   |                |  |  |  |                          |   |  |          |                                |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                   |                |  | 21f. LOCATION  |  |                          |   |  |          |                                |  |  |
|  |         |                  |   |                |  | CITY OR TOWN COUNTY STATE  |  |                          |   |  |          |                                |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |                  |   |                |  |  |  |                          |   |  |          |                                |  |  |
| 22b. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |                  |   |                |  |  |  |                          |   |  |          |                                |  |  |
| ACTUAL SIGNATURE   |         |                  | DATE SIGNED   |                |  |  |  |                          |   |  |          |                                |  |  |
| EXAMINER'S NAME  |         |                  | ADDRESS   |                |  |  |  |                          |   |  |          |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                  | 23b. DATE   |                |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                          | 23d. LOCATION                             |  |          |                                |  |  |
| Burial   |         |                  | 7-16 -84  |                |  | Grandview Cemetery   |  |                          | Beaver Falls, Pennsylvania                |  |          |                                |  |  |
| 24. FUNERAL DIRECTOR   |         |                  | 25. DATE RECEIVED BY REGISTRAR  |                |  |  |  |                          |   |  |          |                                |  |  |
| Ruck Towson Funeral Home, Inc. Towson, Md. 21204   |         |                  | JUL 17 1984   |                |  |  |  |                          |   |  |          |                                |  |  |

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• 23 •

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 7 8

FOR  
STATE  
REGISTRAR

REG. NO.

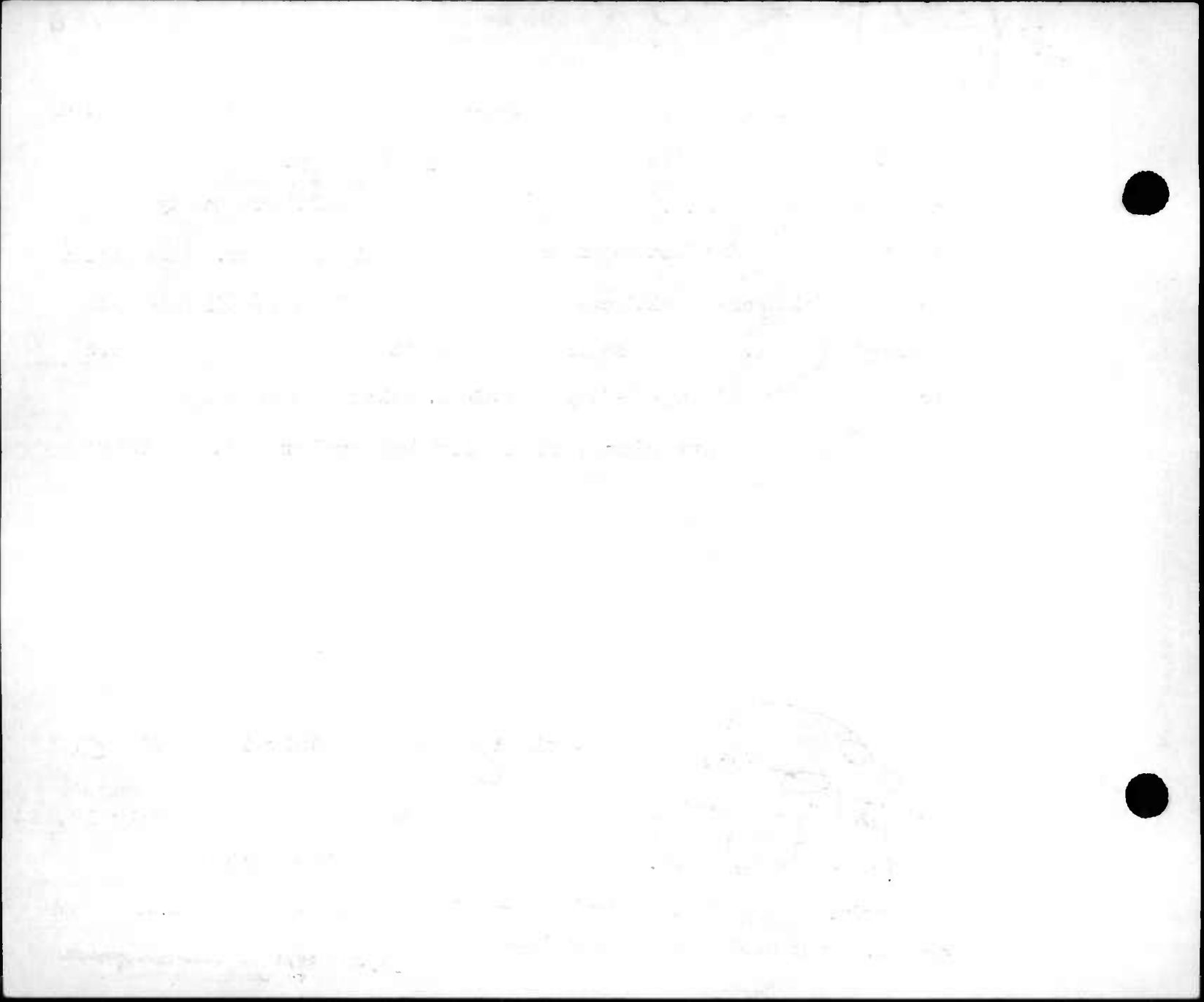
|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Josiah W. Manges   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 18 84                                     |   | 2b. HOUR<br>2:30P M  |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 2 10  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2522 East Joppa Road |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Linotype Oper. |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sun Papers  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |   |   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph C. Manges   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jeanette Horn  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>209-03-3989   |  | 17. INFORMANT<br>ADDRESS<br>Ronald D. Walker Same as 13c  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular dis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>July 7</u> 19 <u>84</u> to <u>July 18</u> 19 <u>84</u> , that (2) we last saw the deceased alive on <u>July 7</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (lower) did not view the body after death.                          |   |   |  |   |  |
| 22b. SIGNATURE<br>  |   | DEGREE  |  | 22c. DATE SIGNED<br>July 19, 84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marc I. Leavey, M.D.  |   | 22e. ADDRESS<br>7600 Osler Drive 21204  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>7/20/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  | 23d. LOCATION<br>Baltimore A.A. Md  |  |
| 24. FUNERAL DIRECTOR<br>George J. Gonce 4001 Ritchie Hwy Balto Md  |   | 25a. DATE REC'D BY REGISTRAR<br>JUL 20 1984   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 7 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                            |  |  |
|---|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Joseph T. Marciano</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>07 10 84</b> |   | 2b. HOUR<br><b>11:55PM</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 22 17</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Connecticut</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>14 Sparrow Hill Ct.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disability Exam. Fed. Govt.</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph A. Marciano</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clorinda Clark</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |                            | 16b. SOCIAL SECURITY NO.<br><b>381 09 6015</b>   |  |
| 17. INFORMANT<br><b>Celestine H. Marciano</b>   |  | ADDRESS<br><b>same as 13c</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Prostate Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mo.</b><br><b>2 1/2 YRS</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11c   |  |   |  |   |                            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> , 19 <b>82</b> , to <b>7/10</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased expire on <b>6/27</b> , 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |   |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>William C. Waterfield</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |                            | 22c. DATE SIGNED<br><b>7/12/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William C. Waterfield M.D.</b>  |  | 22e. ADDRESS<br><b>900 Caton Ave. Baltimore, MD. 21229</b>  |  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>07-14-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Cemetery</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy &amp; Russell Witzke</b>   |  | ADDRESS<br><b>1630 Edmondson Ave.<br/>Catonsville, MD. 21228</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 13 1984</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the four after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |   |  |  |   |                                   |   |  |   |  |
|--|---|--|--|---|-----------------------------------|---|--|---|--|
| 1- FOR STATE REGISTRAR   |   | 2a. DATE KNOWN OF DEATH  |  | 2b. DATE OF ESTIMATED DEATH   |                                   | 2c. DATE PRONOUNCED DEAD                |  | 2d. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | FIRST  |  | MIDDLE  |                                   | LAST                                    |  | 2e. HOUR  |  |
| Neta Frances Marsteller  |   |  |  |   |                                   |   |  | 4:45 AM   |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH (MONTH DAY YEAR)  | 6. AGE (IN YEARS LAST BIRTHDAY)  | 7. IF UNDER 1 YR. MONTHS  | 8. IF UNDER 24 HRS. HOURS         |   |  |   |  |
| Female   | White   | Apr. 19, 1908  | 76 YRS.  |   |                                   |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                                   |   |  |   |  |
| Virginia   | USA   |  |  | Baltimore County  |                                   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |   |  |
| Towson   | Greater Baltimore Medical Center  |  | Laborer  |   | Food Processing                   |   |  |   |  |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS   |                                   |   |  |   |  |
| Maryland   | Baltimore   | Freeland   |  | 1710 Walker Road  |                                   |   |  | 21053   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |   | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                            |                                   | 16b. SOCIAL SECURITY NO.                |  | 17. INFORMANT ADDRESS                               |  |
| William Buckley Jacobs   |   | Laura Utz  |  | no  |                                   | 162-26-4803                             |  | 1710 Walker Rd. Gilbert F. Marsteller, Freeland, MD |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |                                   | DUE TO, OR AS A CONSEQUENCE OF          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
|  |   |  |  | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |                                   | (b)                                     |  | 5-7K  |  |
|  |   |  |  |   |                                   | (c)                                     |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |   |  |  |   |                                   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |                                   |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                 |                                   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                                   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |   |  |  |   |                                   |   |  |   |  |
| ACTUAL SIGNATURE   |   | TITLE (SPECIFY)  |  | MEDICAL EXAMINER  |                                   | DATE SIGNED                             |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |   | ADDRESS  |  |   |                                   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE (SPECIFY)  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |   |  |
| Burial   |   | Aug 2, 1984  |  | Hampstead Cemetery  |                                   | Hampstead, Carroll, MD                  |  |   |  |
| 24. FUNERAL DIRECTOR NAME  |   | Second at Franklin   |  | DATE REC'D BY REGISTRAR   |                                   | 25b. REGISTRAR'S SIGNATURE              |  |   |  |
| J. J. Hartenstein, New Freedom, PA   |   | 17349  |  | AUG 6 1984  |                                   | John Davidson-Randall                   |  |   |  |

THE UNIVERSITY OF CHICAGO  
LIBRARY



UNIVERSITY OF CHICAGO  
LIBRARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified and the medical certificate completed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  | 8 4 1 8 1 8 1   |     |  |          |
|--|--|--|--|--|--|--|--|---|--|---|-----|--|----------|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |  |  |   |  |   |     |  |          |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH   |  | MONTH   | DAY | YEAR   | 2b. HOUR |
| Charles  |  | R  |  |  |  | Martin   |  | 7/1/1984  |  | 6   | 45  | PM   | M        |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS   |     |  |          |
| Male   |  | Caucasian  |  | 2 17 1889  |  | 95   |  | MONTHS  |  | DAYS  |     | HOURS MIN.                                   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |     |  |          |
| MARYLAND   |  | U.S.A.   |  |  |  | BALTIMORE COUNTY MD.   |  |   |  |   |     |  |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |   |     |  |          |
| TOWSON   |  | DULANEY TOWSON Nurs+Care Home  |  | MEAT CUTTER  |  | FOOD   |  |   |  |   |     |  |          |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |   |     |  |          |
| MARYLAND   |  |  |  | BALTIMORE  |  |  |  | 111 CENTRE STREET 21201   |  |   |     |  |          |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |   |  |   |     |  |          |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |  |  |   |  |   |     |  |          |
| FRANK  |  | MARTIN   |  | BARBARA RYTINA   |  |  |  |   |  |   |     |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |   |  |   |     |  |          |
| NO   |  | 213-01-1962  |  | WILLIAM A. MARTIN  |  | 101 CENTRE PLACE, BALTIMORE, MD.   |  |   |  |   |     |  |          |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |   |  |   |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u>  |  |  |  |  |  |  |  |   |  |   |     | 2 days                                       |          |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u>  |  |  |  |  |  |  |  |   |  |   |     | 10 yrs                                       |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Stroke</u>   |  |  |  |  |  |  |  |   |  |   |     | 2 yrs  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |   |  |   |     |  |          |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |     |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |     |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |     |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-18</u> 19 <u>82</u> , to <u>7-1</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6-21</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |   |     |  |          |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |   |     |  |          |
| Frederick J. Vollmer, MD   |  |  |  |  |  |  |  | 7-2-84  |  |   |     |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |   |  |   |     |  |          |
| FREDERICK J. VOLLMER   |  |  |  | 6100 YORK RD BALTIMORE, MD 21212   |  |  |  |   |  |   |     |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |     |  |          |
| BURIAL   |  |  |  | 7-3-84   |  | PARKWOOD CEM.  |  | BALTIMORE BALTIMORE MD  |  |   |     |  |          |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |     |  |          |
| NICHOLAS T. MATTHEWS, 3021 EASTERN AVE. BALTIMORE, MD.   |  |  |  | JUL 3 1984   |  |  |  | John Davidson-Randall   |  |   |     |  |          |

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99. [illegible]  
100. [illegible]

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 4 1 8 1 8 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                    |  |  |   |                  |   |  |
|---|--|--|--|---|--------------------|--|--|---|------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>FLORA NADINE MAXWELL  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 27, 1984 |   | 2b. HOUR<br>030 AM |  |  |   |                  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 8, 1902   |                    | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>81 YRS   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS                                  |                  | 7. UNDER 24 HRS<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Mississippi   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |   |                  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2019 Cedar Circle Drive |  |   |                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                   |                  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |                    |  |  |   |                  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Catonsville  |                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>2019 Cedar Circle Drive 21228 |                  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Attie Frank Parker  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances Flora Shannon  |                    |  |  |   |                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>218-80-5682   |                    | 17. INFORMANT<br>ADDRESS<br>Richard F. Maxwell Jr. Same as # 13  |  |   |                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cerebrovascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Arteriosclerotic Cardiovascular Disease</u> |  |  |  |   |                    |  |  |   |                  |   |  |
| 19a. DATE OF OPERATION  |  |  |  |   |                    |  |  |   |                  |   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |   |                    |  |  |   |                  |   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |                    |  |  |   |                  |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |                    |  |  |   |                  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                    |  |  |   |                  |   |  |
| 22a. SIGNATURE<br>Eric Fisher   |  |  |  |   |                    | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22b. DATE SIGNED |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Eric Fisher M.D.   |  |  |  |   |                    | 22e. ADDRESS<br>Maryland General Hospital, Baltimore, Md.  |  |   |                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |  |  | 23b. DATE<br>7/28/84  |                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial Park   |  |   |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Md. |  |
| 24. FUNERAL DIRECTOR<br>Edmondson & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, Md. 21228   |  |  |  |   |                    | 25a. DATE REC'D. BY REGISTRAR<br>JUL 31 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall                  |                  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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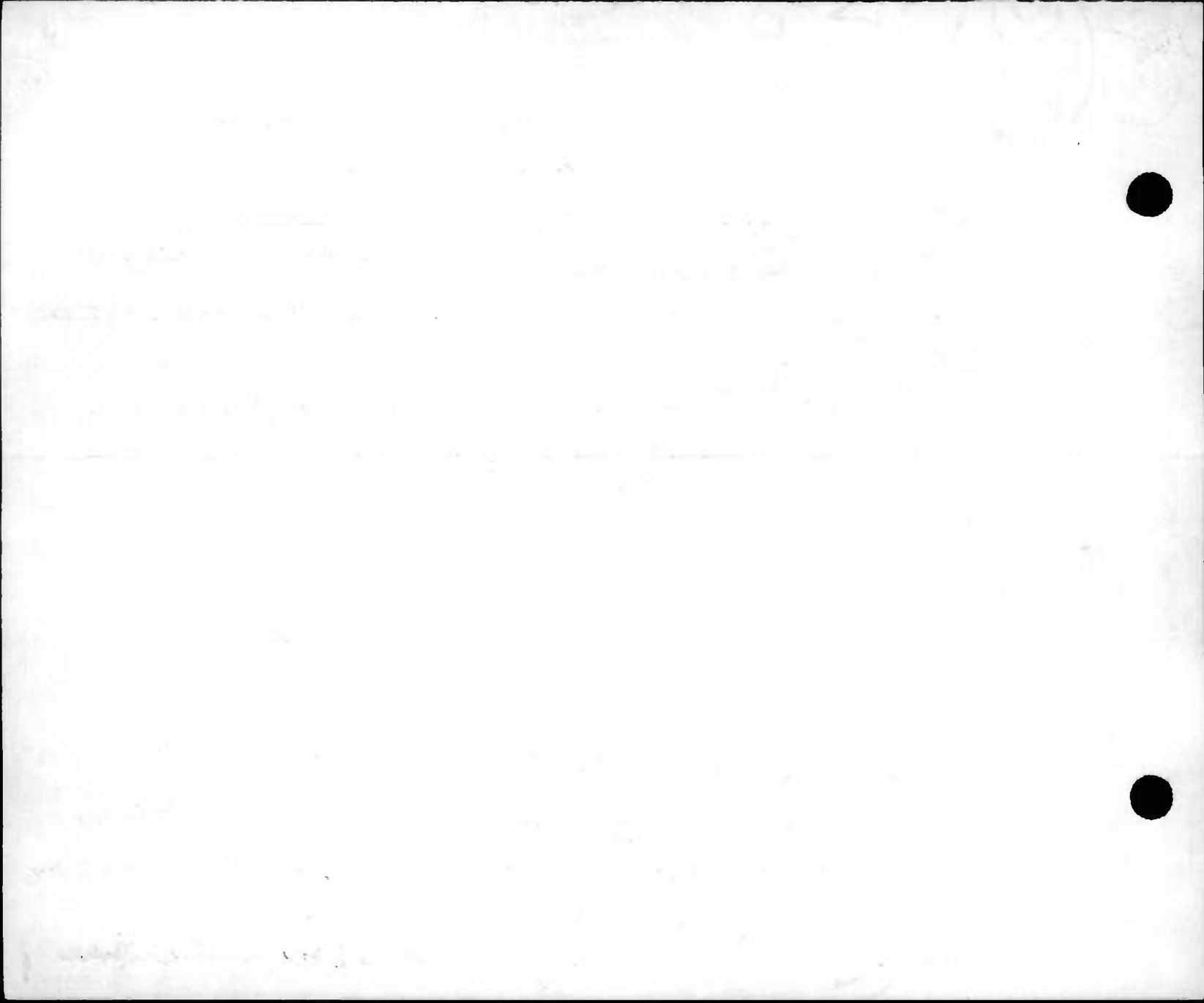
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1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>John M</b>   |  | FIRST MIDDLE LAST<br><b>Mc Carty, Sr/</b>   |  | 2a. DATE OF DEATH<br><b>July 11, 1984</b>   |  | MONTH YEAR  |  | 2b. HOUR   |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 6. 1927</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |   | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8913 Waltham Woods RD Apt C</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bureau of Parks</b>      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b> |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8913 Waltham Woods Road 21234</b>   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. McCarty</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Duncan</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b>   |  |   |  |  |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-20-7574</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Evelyn A McCarty 8913 Waltham Woods Rd.</b>  |  |   |  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic lung cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.              |  |   |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><br>  |  |   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 23</b> , 19 <b>84</b> , to <b>July 11</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>June 29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>7/11/84</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES H MURPHY</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>6701 N. CHARLES ST BALTIMORE 21204</b>                                       |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>July 14, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park Baltimore Md.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Md.</b>   |  |   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 12 1984</b>  |  |  |   |  |  |
|   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 1 8 1 3 4

REG. NO.

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mrs. Ethel M. McComas</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 28 1984</b>  |  |   |  | 2b. HOUR<br><b>11:30 A</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 9 1891</b>   |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired School</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Teacher</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Granite</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>10501 Old Court Road 21163</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James J. Miller</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ellen Taggart</b>  |  |   |  | ADDRESS<br><b>Mrs. Jean Wagers 21157</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-74-0061</b>   |  | 17. INFORMANT<br><b>Mrs. Jean Wagers</b>  |  | ADDRESS<br><b>193 Bell Road Westminster Maryland</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis &amp; dehydration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Organic brain syndrome</b>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>9</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased gave an opinion (we) did not view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Gregory K. McAuliffe, M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>7.28.84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS<br><b>Balto Co Gen Hosp Randallstown Md</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-31-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Granite Church Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Granite Baltimore Maryland</b>                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>   |  |   |  | 25. DATE RECEIVED BY REGISTRAR<br><b>JUL 30 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Randall</b>                                       |  |  |  |
| 8728 Liberty Road Randallstown, Maryland 21133  |  |   |  |   |  |   |  |  |  |

MEDICAL CERTIFICATION

1200 AT ET

488

### 1634 Results

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

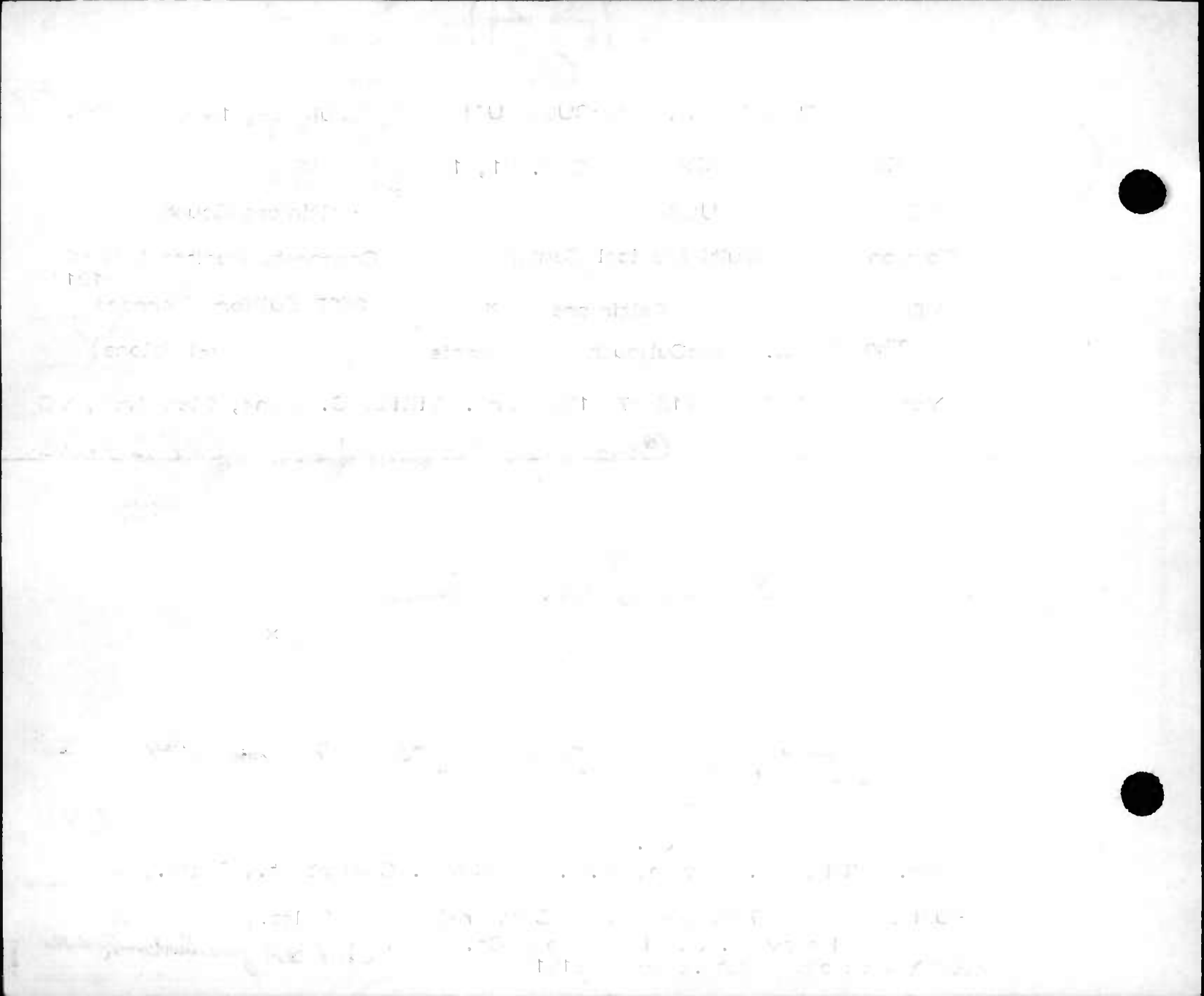
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 11 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

18418185

|   |  |  |  |                  |  |
|---|--|--|--|------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | MONTH DAY YEAR   |  | a                |  |
| MICHAEL J. McCULLOUGH   |  | July 26, 1984  |  | 8:39 M           |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                | IF UNDER 1 YEAR  |  |
| Male  | White  | MONTH DAY YEAR   | 95 YRS.  | IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                  |  |
| MD  | USA  |  | Baltimore County MD  |                  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                  |  |
| Towson  | Multi-Medical Center   | Corporate Auditor-USF&G  |  |                  |  |
| 13a. STATE  | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?   | 13d. STREET ADDRESS / ZIP CODE                                 |                  |  |
| MD  | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 3437 Guilford Terrace 21218                                    |                  |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                  |  |
| Thomas J. McCullough  | Annie Malone   | Yes  |  |                  |  |
| 16b. SOCIAL SECURITY NO.  | 17. INFORMANT  | ADDRESS  |  |                  |  |
| 215 07 8122   | Mrs. William C. Mank, Glen Arm, MD   |  |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cerebral Infarcts   |  |  |  |                  | 6 mos  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |                  |  |
| Coronary A. Disease   |  |  |  |                  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                  |  |
|   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                  |  |
|   | HOUR A.M. MONTH DAY YEAR   |  |  |                  |  |
|   | P.M. 19  |  |  |                  |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)                                       | 21f. LOCATION  |  |                  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | CITY OR TOWN COUNTY STATE  |  |                  |  |
| 22a. I certify that (I) (the undersigned) attended the deceased from 8/14, 1983, to 7/26, 1984, that (I) (we) lost saw the deceased alive on 7/14, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |                  |  |
| 22b. SIGNATURE  |  |  |  |                  | 22c. DATE SIGNED                             |
| William P. Benson Jr.   |  |  |  |                  | 7/26/84                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |                  | 22e. ADDRESS                                 |
| Dr. William P. Benson, M.D.   |  |  |  |                  | 3506 N. Calvert St., Balto., MD              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION  |                  |  |
| Burial  | 7/30/84  | New Cathedral  | Balto., MD   |                  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  | 25a. DATE REC'D BY REGISTRAR                                   |                  |  |
| Henry W. Jenkins & Sons Co.   |  |  | JUL 27 1984  |                  |  |
| 4905 York Road Balto., MD 21212   |  |  | 25b. REGISTRAR'S SIGNATURE                                     |                  |  |
|   |  |  | John Henderson-Randall   |                  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called upon.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |   |  |   |  |  |
|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Margaret Gertrude McDonald</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 14, 1984</b>                   |   |   | 2b. HOUR<br><b>2:50 A</b>  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 13, 1902</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>81</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dulaney Towson Nursing Home</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaking</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Cockeysville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Franklin Barrett</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Mae Wilhelm</b>    |   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>10701 York Road, #21030</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-20-1958</b> |   | 17. INFORMANT ADDRESS<br><b>Mr. William H. McDonald, 10310 Greentop Rd. Cockeysville, Md.</b> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Chronic CHF</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sent. 1983</b><br><b>Sept. 1983</b>                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Right middle cerebral artery thrombosis</b>   |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                 |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 9</b> 19 <b>74</b> to <b>July 14</b> 19 <b>84</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>June 22</b> 19 <b>84</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death. |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Donald O. Wood</i>   |  |   | DEGREE<br><b>MD</b>   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7/16/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald O. Wood, MD</b>  |  |   | 22e. ADDRESS<br><b>2 Greenmeadow Dr. Timonium, 21093</b>                      |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>16 Jul 1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Poplar Grove U. Meth.</b>                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Phoenix, Balto. Co., Maryland</b>              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Martin D. Lawson</b>   |  |   | 24b. ADDRESS<br><b>10 W. Padonia Rd., Timonium</b>                            |   | 24c. ZIP CODE<br><b>21093</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>JUL 16 1984</b>  |  |  |
| 25a. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                            |   |   |  |   |  |  |

BP \_\_\_\_\_



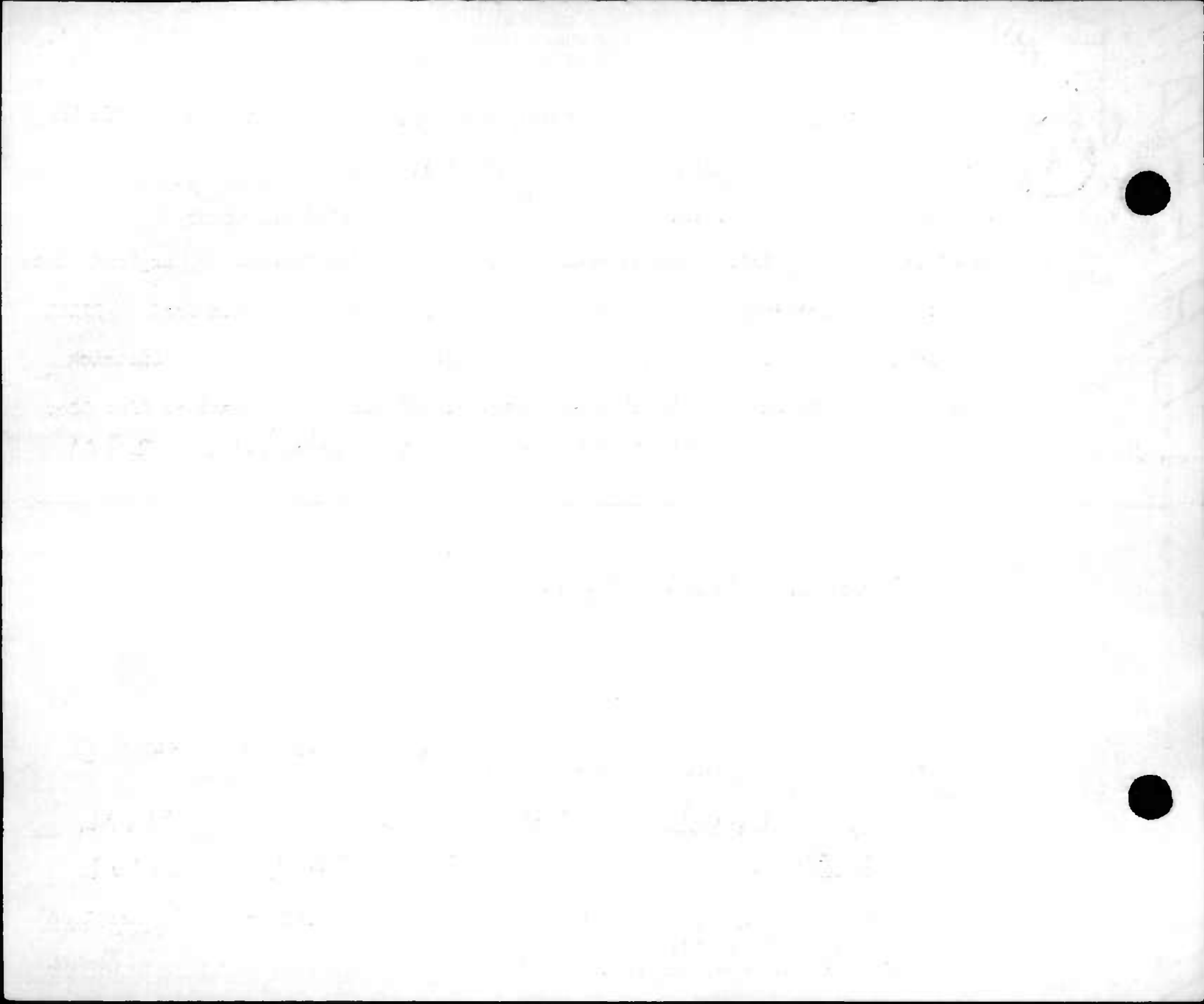


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | REG. NO. |  |
|---|--|--|--|---|--|--|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Luke W McKittrick, Sr.</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 6 84</b>   |  | 2b. HOUR<br><b>5:05A<sub>M</sub></b>   |  |          |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 26 1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>   |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7515 Lawrence Road</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland State</b>   |  |          |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7515 Lawrence Road 21222</b>  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Luke M. McKittrick</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Dietrick</b>  |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |  | 17. INFORMANT<br><b>Mary A. McKittrick</b>  |  | 17b. ADDRESS<br><b>Same as Line 13e</b>  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF RECTUM metastatic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> |  |  |  |   |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Schemic heart disease.</b>   |  |  |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>333 ST PAUL Baltimore Maryland</b>  |  |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 19 84</b> , to <b>JULY 6<sup>th</sup> 19 84</b> , that (I) (we) last saw the deceased alive on <b>JUNE 19 84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br><b>Adrian E. Walsh</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7-6-84</b>  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Adrian Walsh</b>  |  |  |  | 22e. ADDRESS<br><b>333 ST PAUL 21202</b>  |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/9/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>  |  |  |  | ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 11 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO.  |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Alice Virginia Mehren  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 - 21 - 84   |  |  |  | 2b. HOUR<br>1:00 AM   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 10 1891   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. County MD.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>WOODLAWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Arlington Baptist Nursing Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOME MAKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME  |  |   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>TOWSON   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>TABCO TOWERS JOPPA ROAD   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Newton Enos  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice DeShazo  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>212-03-7871A  |  | 17. INFORMANT<br>ADDRESS<br>DONALD N. BENNETT 701 INDIAN SPRING CT.   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>One day-24 hrs</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/9</u> , 19 <u>80</u> , to <u>7/21/84</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>7/20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  | DEGREE<br><u>M.D.</u>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7/21/84  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Darold K. Beard MD  |  |   |  | 22e. ADDRESS<br>11 East Chestnut Hill Lane, Reisterstown MD   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>JULY 23, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>LEROY M. & RUSSELL C. WITZKE FUNERAL HOME OF CATONSVILLE<br>1630 EDMONDSON AVE. BALTIMORE MARYLAND 21228   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 23 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |

STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1904



REPORT

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 1, 1904

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |   |  |   |   |  |
|--|--|--|---|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Frederick H. MEIER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 16, 1984</b>             |   | 2b. HOUR<br>A. M.<br><b>8:30</b>                                   |  |   |  |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-4-1909</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>75</b>   |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>75</b>  |   | 8. UNDER 24 HRS.<br>HOURS MIN.<br><b>75</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. County</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Pattern-Maker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>American</b>   |   |   |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4303 Belmar Ave. - 21206</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Meier</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Lehner</b> |   |  |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-4308</b>                          |   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Mary E. Meier - 4303 Belmar Ave. - 21206</b>   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Cardiovascular (vessels)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Disease</b> |  |  |   |   |  |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/6/68</b> , 19____, to <b>7/16/84</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/14/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did not) view the body after death.   |  |  |   |   |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>A. Alevizatos, M.D.</b>   |  |  | DEGREE  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>7/17/84</b>                                |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. ALEVIZATOS, M.D.</b>  |  |  | 22e. ADDRESS<br><b>301 ST. PAUL Place Balto, Md</b>                     |   |  |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>7-19-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Evangelical Luth</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Stemmers Run Md</b>   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>  |  |  | ADDRESS<br><b>6415 Belair Rd.-21206</b>                                 |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 17 1984</b>  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                  |   |  |

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MEDICAL CERTIFICATION  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

John C. Williams, Inc. 7140-2nd Edition 2015-18

Date \_\_\_\_\_ Page \_\_\_\_\_

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Journal

John C. Miller Inc. 714-215-1508

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1991-1992

Submitted (over)

*(continued)*

70515-944 awarded \$684

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2015-01-10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH.

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

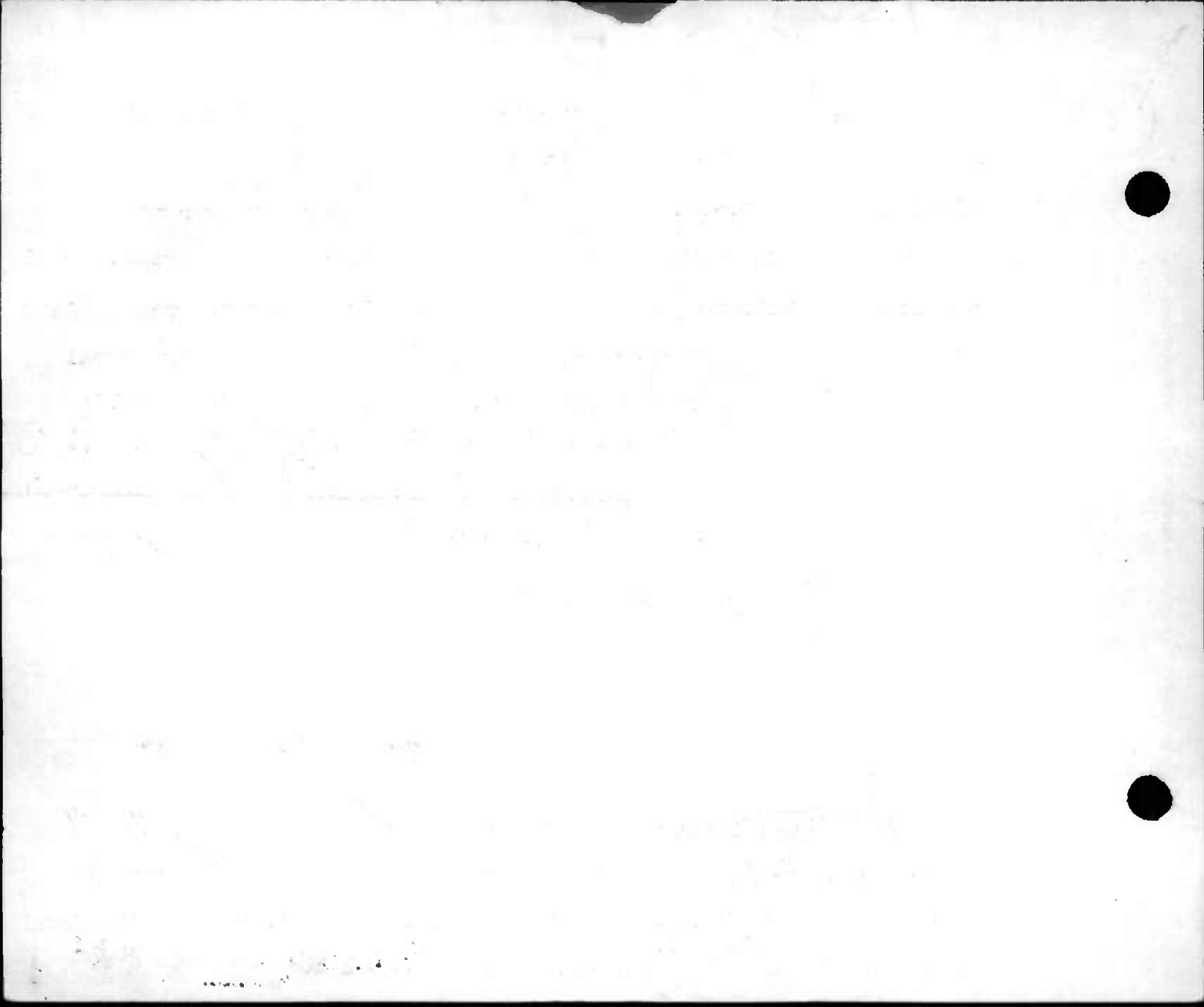
|  |                         |   |  |   |                      |
|--|-------------------------|---|--|---|----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Jacob Mekolon</b>  |                         |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>10</b> YEAR <b>84</b> |   | 2b. HOUR<br><b>M</b> |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>24</b> YEAR <b>1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                 |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                |                      |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1845 Stengel Road</b>                               |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tinner</b> |                      |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>  |                         |   |  |   |                      |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |                      |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                         | 13e. STREET ADDRESS / ZIP CODE<br><b>1745 Stengel Road 21222</b>  |  |   |                      |
| 14. FATHER'S NAME<br>FIRST <b>Jacob</b> MIDDLE <b>Mekolon</b> LAST <b>Sr.</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Brodowski</b> LAST <b>Brodowski</b>   |  |   |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>213-07-1274</b>  |  | 17. INFORMANT<br><b>Ruth Mekolon</b>  |                      |
| 18a. CAUSE OF DEATH (Enter only one cause per line by (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction → Cardiac dysrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>ASCD</b><br><b>20 years</b> |                         | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br><b>Actual fibrillation, CHF</b> |  |   |                      |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |                      |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                         |   |  |   |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |                      |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 74</b> to <b>7/12</b> <b>19 84</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                         |   |  |   |                      |
| 22b. SIGNATURE<br><b>Hector C. Feliciano</b>   |                         | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>7/11/84</b>  |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HECTOR C. FELICIANO M.D.</b>   |                         | 22e. ADDRESS<br><b>7200 W. Point Rd 21219</b>   |  |   |                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>7/13/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Christ Lutheran</b>                      |                      |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |                         |   |  |   |                      |
| 24. FUNERAL DIRECTOR<br>NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>   |                         | 25a. DATE REC'D. BY REGISTRAR <b>JUL 12 1984</b> 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodgers</b>  |  |   |                      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to autopsify.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2373.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 84 18191  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>William Earl Meredith</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>July 18, 1984</b>  |  |   |  |
| 3. SEX <b>Male</b>   |  |   |  | 2b. HOUR <b>5 p.m.</b>   |  |   |  |
| 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 8 1898</b>                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>   |  | 10. CITY OR TOWN OF DEATH <b>Reisterstown</b>                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>12370 Boncrest Dr.</b>                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Type Setter</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <b>B-0</b>   |  | 13a. STATE <b>MD.</b>   |  | 13b. COUNTY <b>Balt.</b>   |  | 13c. CITY OR TOWN <b>Reist.</b>   |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>12370 Boncrest Dr.</b>                       |  | 13f. <b>21136</b>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie Todd</b>       |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>705 05 6716</b>                         |  | 17. INFORMANT ADDRESS <b>Mary Tawney 12370 Boncrest Dr.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic CV Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b></b>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 15, 1984</b> to <b>July 18, 1984</b> , that (I) (we) last saw the deceased alive on <b>July 16, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>C. E. McWilliams M.D.</b>  |  | DEGREE <b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>7-19-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. E. McWilliams M.D.</b>   |  | 22e. ADDRESS <b>11904 Reisterstown Rd., Reisterstown Md 21136</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>July 19, 84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Carroll Cremation</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hampstead Carroll Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home</b>  |  | ADDRESS <b>11824 Reist. Md.</b>                                     |  | 25a. DATE REC'D. BY REGISTRAR <b>JUL 24 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Davidson-Rendall</b>  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HEDIVIG Martha METZGER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-27-84</b> |   |  | 2b. HOUR<br><b>12:50 AM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-10-04</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>79</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County Gen. Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Saleslady</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Jahnichen</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Selma (unknown)</b>  |   | 13e. STREET ADDRESS<br><b>3622 Reisterstown Rd. 21215</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>21630 7894</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Nathan Metzger same as 13e</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>DIABETES MELLITUS</b>   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-9-</b> 19 <b>84</b> to <b>7-27</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7-27</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                            |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Vondy R. Reddy</b>  |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>7-27-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VONDY R. REDDY</b>   |  | 22e. ADDRESS<br><b>Baltimore County Gen. Hosp Randallstown MD 21133</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>Cremation</b>   |  | 23b. DATE<br><b>07/28/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley, Inc. Dundalk, MD 21222</b>   |  |  |   | 25a. DATE RECD. BY REGISTRAR (24) REGISTRAR'S SIGNATURE<br><b>JUL 30 1984</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 4 1 8 1 9 3  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Myrtle Irene Miller</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 23, 1984</b>  |  |  |  | 2b. HOUR<br><b>5 a.m.</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 25, 1933</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11810 Park Heights Ave.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>11810 Park Heights Ave. 21117</b>   |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Owings Mills</b>  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Orvis Resh</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nora Bittinger</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-62-0277</b>  |  | 17. INFORMANT<br><b>Ray M. Miller</b>  |  | 1810 Park Heights Ave.,<br>Owings Mills, Md. 21117   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Years</u><br><u>Years</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 10, 1975</u> to <u>July 23, 1984</u> , that (I) (we) last saw the deceased alive on <u>July 20, 1984</u> and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>C.E. McWilliams</u> MD   |  |   |  |   |  | 22c. DATE SIGNED<br><u>7-24-84</u>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>C.E. McWilliams</u>   |  |   |  |   |  | 22e. ADDRESS<br><u>11904 Kenton Rd Kenton Md. 21136</u>                              |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>July 25, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Mem. Gar.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Finksburg, Carroll, Md.</b>         |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>H. G. Ebbhardt</u> <u>Owings Mills, Md.</u>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 30 1984</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Johanna Davidson-Randall</u>  |  |  |  |

BP

100

July 22, 1964

Miller

James

Miller

NO

July 22, 1964

Miller

Miller

Delaware County

U.S.A.

Miller

Housewife

1210 Oak Ridge Ave.

Chicago, Ill.

1111

No.

Miller

Miller

1111

1210 Oak Ridge Ave.

Chicago

Miller

Miller

Miller

1210 Oak Ridge Ave.  
Chicago, Ill.

Ray H. Miller

100-100000-100

No.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 9 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                            |
|---|--|---|---|---|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNA K. MITZEL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 10, 1984</b> |   | 2b. HOUR<br><b>12:50 A</b> |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/1/1898</b>                                |                            |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. City</b>   |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                            |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>  |   |   |                            |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |                            |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STREET ADDRESS / ZIP CODE<br><b>3113 Garden Ave., 21234</b>  |   |   |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Wachter</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Funk</b>  |   |   |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-4436</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mildred E. Price 3113 Garden Ave. Balto., MD 21234</b> |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Urinary Tract Infection with</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Gram Negative Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |   |                            |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)        |                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-10-84</b> to <b>7-10-84</b> , that (I) (we) lost the deceased on <b>8-10-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.   |  |   |   |   |                            |
| 22b. SIGNATURE<br><b>A.H. Ghiladi</b>   |  | DEGREE<br><b>A.H. GHILADI, M.D.</b>   |   | 22c. DATE SIGNED<br><b>7-10-84</b>  |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.H. GHILADI, M.D.</b>  |  | 22e. ADDRESS<br><b>7600 OSLER Dr. Towson 21204</b>  |   |   |                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/13/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>                        |                            |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Balto.</b>  |  | 23e. LOCATION<br>CITY OR TOWN STATE<br><b>Balto., MD</b>  |   |   |                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller, Inc. 6415 Belair Rd. 21206</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 13 1984</b>   |   |   |                            |
| 25b. REGISTRAR'S SIGNATURE<br><b>John C. Miller</b>   |  |   |   |   |                            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

515-02-6430

100-31101



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 1 9 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>AGNES R MOESLEIN</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 19 1984</b>                           |  | 2b. HOUR<br><b>9:10</b> M.   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 21 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital -Towson</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaking</b>                               |  |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>8720 EMGE RD 21234</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gustavus Heckel</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnes Roth</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.<br><b>217-58-5495</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Lillian Reichart 4814 Long Green Rd.</b>              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Sepsis - probably due to</b>   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>? days.</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-19-84</b> to <b>7-19-84</b> , that (I) (we) last saw the deceased alive on <b>7-19-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |  |  |
| 22b. SIGNATURE<br><b>A.H. Chiladi</b>  |   | DEGREE   |  | 22c. DATE SIGNED<br><b>7-20-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.H. CHILADI, M.D.</b>   |   | 22e. ADDRESS<br><b>7600 OSLER Dr. Towson 21204</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>7-23-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>  |   | ADDRESS<br><b>7401 Belair Rd. Balto., Md. 21204</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1984</b>                                  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John David Rindler</b>  |   |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

W.D. & H.O. WILLS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

3  
1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Vera Lillian MUELLER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 29, 1984   |   |  | 2b. HOUR<br>8:25AM   |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 24 15  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rosedale   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bookbinder                         |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Publishing  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Mac Duff Taylor   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ola Massengill  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>No |   |  |  |
| 16b. SOCIAL SECURITY NO.<br>424-34-9302   |  |   | 17. INFORMANT<br>ADDRESS<br>Marjorie F. Costa 5417 Rimmell Ave., 21206   |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Asystole<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).<br>Cancer of Breast with Metastases to Lung  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that X (this hospital) attended the deceased from July 18, 1984, to July 29, 1984 that X (we) lost saw the deceased alive on July 29, 1984, and that in (my) (our) opinion death occurred on the date and from the causes stated above X (we) (did) (did not) view the body after death.                                   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>Thomas Lampone  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>7/29/84  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas Lampone, M.D.   |  |   | 22e. ADDRESS<br>9000 Franklin Square Drive 21237   |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>08-01-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Maryland Nat'l Mem. Pk.                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel P.G. Maryland                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.  |  |   | ADDRESS<br>4107 Wilkens Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 1 1984                                    |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson   |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |
| 1. FOR STATE REGISTRAR   |  |   |  |  | REG. NO.   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROBERT MUIR</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 5, 1984</b>  |  |  | 2b. HOUR<br><b>4:45 a.m.</b>                                      |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Dec. 31 1920</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                                     |  | # UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Glasgow, Scotland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING 1 YEAR)<br><b>Technician</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chester Co. Med. Ctr.</b> |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Cecil Port Deposit</b>  |  |   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>P.O. Box 75 21904</b>   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Muir</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Marion Williamson</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>219-34-1020</b>  |  | 17. INFORMANT ADDRESS<br><b>Mary L. Muir Port Deposit, Md. 21904</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic and hypertensive cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Collapse of thoracic vertebra (? tumor)</b>            |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a<br><b>Collapse of thoracic vertebra (? tumor)</b>   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>Port Deposit Cecil Maryland</b>  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/27</b> , 19 <b>84</b> , to <b>7/05</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/05</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Rudiger Breitenecker</i>  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>July 5, 1984</b>                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rudiger Breitenecker, M.D.</b>   |  |   |  |  | 22e. ADDRESS<br><b>6701 N. Charles St. Baltimore MD 21204</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>July 9, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cratin and Ferris</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>West Chester Chester Penn.</b>         |  |   |  |
| 24. BY THE REGISTRAR<br><i>[Signature]</i>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 10 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |  |

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*[Handwritten signature]*

1, 1905



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
Charles W. Muller

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
July 22, 1984 7:15 A.M.

3. SEX  
Male4. RACE  
White5. DATE OF BIRTH  
MONTH DAY YEAR  
Oct. 11, 19066. AGE (IN YEARS LAST BIRTHDAY)  
77 YRS.  
IF UNDER 1 YEAR IF UNDER 24 HRS.  
MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
N.Y.7b. CITIZEN OF WHAT COUNTRY?  
U.S.A.8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH  
Baltimore County MD10. CITY OR TOWN OF DEATH  
Timonium11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
4 Thrush Court12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Ins. Mgt.12b. KIND OF BUSINESS OR INDUSTRY  
InsuranceUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE 13b. COUNTY 13c. CITY OR TOWN  
FLA. Broward Ft. Lauderdale13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐13e. STREET ADDRESS  
4887 North West 43rd Ct14. FATHER'S NAME  
FIRST MIDDLE LAST  
Alfred Hofmeister15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
Annie unk16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)  
yes16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)  
WW II 100 03 249617. INFORMANT ADDRESS  
Audrey Thompson Timonium, MD 2109318. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Brain Tumor (Glioblastoma)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

None

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
Glioblastoma

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE NOT WHILE  
AT WORK ☐ AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from June 1984 to July 1984, that (I) (we) lost saw the deceased above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

7/22/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Don Mlang MD

22e. ADDRESS

Johns Hopkins Hospital

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

7-25-84

23c. NAME OF CEMETERY OR CREMATORY

Queen of Heaven Cemetery

23d. LOCATION  
CITY OR TOWN COUNTY STATE

North Lauderdale FLA.

24. FUNERAL DIRECTOR

NAME ADDRESS  
Michael Marzullo Rietzstown, Md.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JUL 23 1984

Julia Davidson-Randall

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418199

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Janet Evelyn Mulligan (McCray)</b> |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>July 10/84</b>  |  | 2b HOUR<br><b>10:30 P.M.</b>   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>CAUCASIAN</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>12 3 24</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>U.S.A. Baltimore</b>                           |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                             |  |
| 10 CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>21228 Spring Grove Hospital Center</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>   |  |
| 13a STATE<br><b>md.</b>   |  | 13b COUNTY<br><b>U-</b>   |  | 13c CITY OR TOWN<br><b>Baltimore</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Louis molz</b>                                       |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Viola molz</b>  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                    |  |  |  |
| 16b SOCIAL SECURITY NO.<br><b>214-40-3469</b>   |  | 17 INFORMANT ADDRESS<br><b>PATIENT CHART Spring Grove Hospital</b>  |  |   |  |  |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>May 9, 1984</b> to <b>July 10, 1984</b> , that (I) (we) last<br>saw the deceased alive on <b>July 10, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |

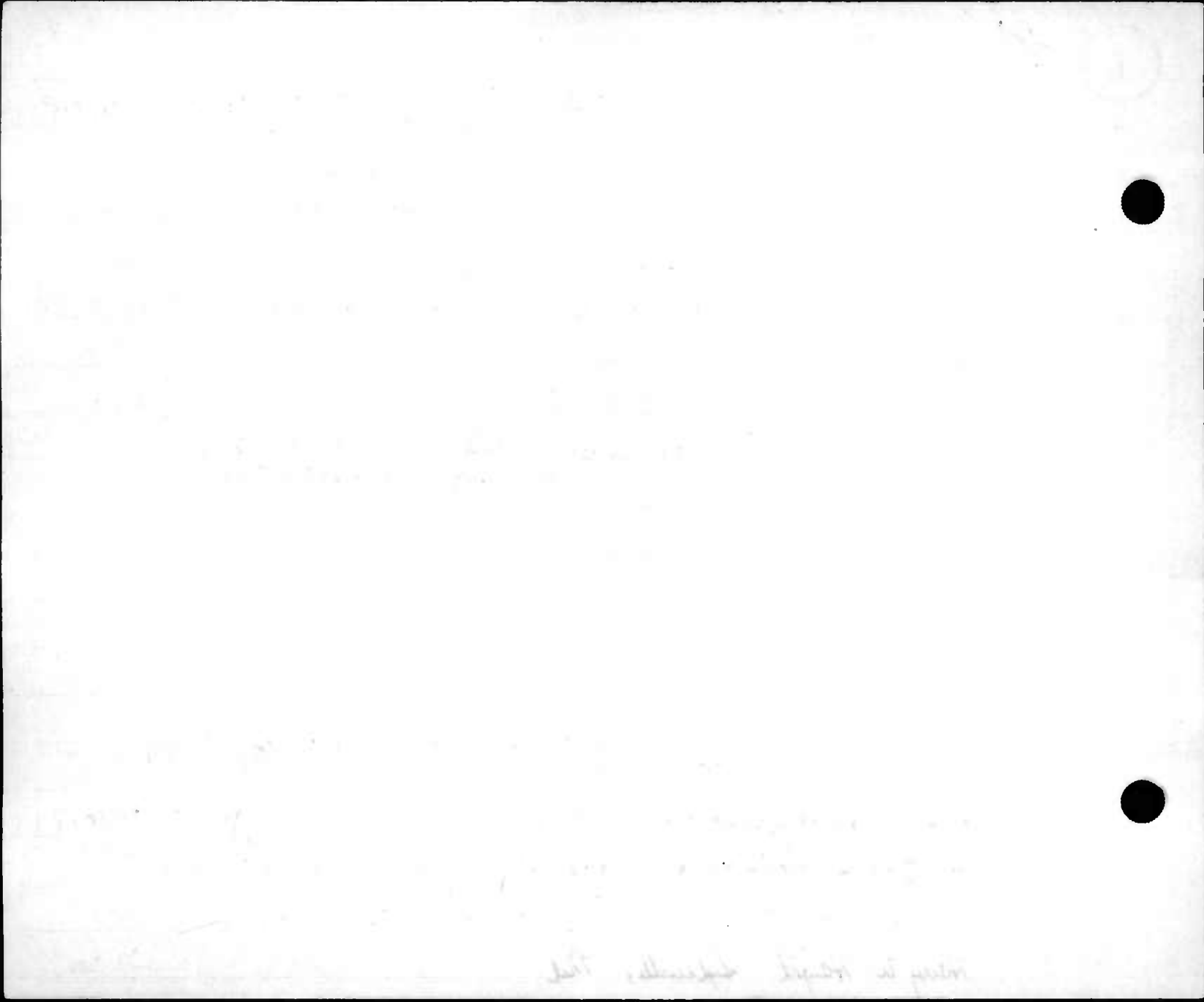
|  |  |  |  |  |  |                                      |  |
|--|--|--|--|--|--|--------------------------------------|--|
| 22b SIGNATURE<br><b>Arjang Mikemadi</b>                              |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>July 10/84</b> |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARJANG MIKEMADI, M.D.</b> |  | 22e ADDRESS<br><b>Spring Grove Hosp. Center Baltimore M.D.</b> |  |  |  |                                      |  |

|   |  |                            |  |  |  |   |  |
|---|--|----------------------------|--|--|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                  |  | 23b DATE<br><b>7-13-84</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>DeSales Valley Mem. Park</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Harry W. Haight Sykesville, Md.</b> |  |                            |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 11 1984</b>                   |  | 25b REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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DHMH-16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers; Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Items 5,15 FilmG596 10/22/84JAB   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 4 1 8 2 0 0  |  |  |  |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR   |  |  |  |
| Joseph E Muse Jr.   |  |   |  | July 19, 1984  |  |   |  | 8AM  |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |
| Male  |  | White   |  | August 29, 1910  |  | 73 YRS.   |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| Maryland  |  | U.S.A.  |  | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | Baltimore County  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |
| Catonsville   |  | Summit Nursing Home                                     |  | Physician  |  |   |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                                      |  |  |  |
| Maryland  |  |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6105 Pinehurst Rd.                                       |  | 21212  |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |
| Joseph E Muse   |  |   |  | Laura Muse Travers   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |  |  |
| No  |  |   |  |  |  | Mrs Mary Griffin  |  | 6105 Pinehurst Rd  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |   |  |  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Seizure Convulsion</u>   |  |   |  |  |  |   |  | instantly  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebro Vascular Disease</u>  |  |   |  |  |  |   |  | unknown  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>age</u>   |  |   |  |  |  |   |  | unknown  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED  |  |  |  |  |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |  |  |  |
|   |  |   |  | P.M. 19  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  | CITY OR TOWN   |  | COUNTY STATE   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/17</u> , 19 <u>83</u> , to <u>7/19</u> , 19 <u>84</u> , that (I) <u>did</u> <u>not</u> saw the deceased alive on <u>7/17</u> , 19 <u>84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death. |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  |   |  |  |  |   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| CLIFF RAYLIFE, JR., M.D.  |  |   |  |  |  |   |  | M.D.   |  | 7/20/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |  |  |   |  | 22e. ADDRESS   |  |  |  |
| CLIFF RAYLIFE, JR., M.D.  |  |   |  |  |  |   |  | 5772 WESTVIEW MALL                                       |  | 21228  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION  |  | COUNTY STATE   |  |
| Burial  |  |   |  | July 21, 84  |  | New Cathedral   |  | Baltimore, Maryland                                      |  |  |  |
| 24. FUNERAL DIRECTOR  |  |   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR                            |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Harry H. Witzke 4112 Columbia Pike  |  |   |  |  |  |   |  | JUL 20 1984  |  | H. Witzke  |  |
| Ellicott City, Maryland 21043   |  |   |  |  |  |   |  |  |  |  |  |

[illegible]

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139 G. S. HILL

Environ Biol Fish (2015) 98:1031–1043

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.10+1  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |   |   |   |  |  |
|---|--|--|---|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SAMUEL Joseph NASON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 23 84</b>                       |   | 2b. HOUR<br><b>12-51 PM</b>                                    |   |   |   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 02 17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   | IF UNDER 74 HRS.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto COUNTY</b> MD.   |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN HOP</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.- Corporal Balto. Co. Police</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>Brighton</b>                           |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>6510 PARSONS AVE 21208</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles S. Nason</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Joseph McEnroe</b> |   |  |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. 11</b>   |   | 17. INFORMANT<br><b>Mrs. Ethel May Nason</b>                   |   | ADDRESS<br><b>6510 Parsons Avenue Baltimore, Md. 21215</b>                                      |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD, CHF</b> |  |  |   |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |   |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7-11 19 84</b>        |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                               |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-22 19 84</b> , to <b>7-23 19 84</b> , that (I) (we) last saw the deceased alive on <b>7-22 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |   |   |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Tasneem Lakhani</b> MD   |  |  |   |   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7/23/84</b>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TASNEEM LAKHANI</b>   |  |  |   |   |  | 22e. ADDRESS<br><b>5401 ORO COURT RD, BALTO MD 21133</b>  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>7-26-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b> |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore Maryland</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, Maryland 21133</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                 |  |  |  |   |  |  |  | REG. NO. 18202  |  |
|--|--|---------------------------------|--|--|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |                                 |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Anna Nedelsky</i>   |  |                                 |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTI. MATED <i>July 18 1984</i>  |  | 2b. HOUR <i>5 PM</i>   |  |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>7/13/1905</i>  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <i>79</i> YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br><i>July 18 1984</i>               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  |                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                          |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Upperco</i>  |  |                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>4252 Mount Carmel Road,</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife and Mother</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                 |  |  |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><i>4252 Mount Carmel Rd., 21155</i>                                   |  |   |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i> |  | 13c. CITY OR TOWN<br><i>Upperco</i>  |  |   |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Joseph Capak</i>  |  |                                 |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Theodosia Capak</i>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>no</i>   |  |                                 |  | 16b. SOCIAL SECURITY NO.<br><i>215-07-1821</i>   |  | 17. INFORMANT<br><i>Barbara A. Butler</i>   |  | 17a. ADDRESS<br><i>Powder Mill, Md. 21122<br/>484 Royal Beach Rd.,</i>                       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Uremia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Renal ASCVD</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>3± yrs</i>  |  |                                 |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH<br><i>3± yrs</i> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |                                 |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                                 |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <i>Wanda F. Brown</i>   |  |                                 |  |  |  | TITLE (SPECIFY)<br><i>Deputy Medical Examiner</i>   |  | DATE SIGNED <i>7/18/84</i>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                                 |  |  |  | ADDRESS   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  |                                 |  | 23b. DATE<br><i>7/21/1984</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Trinity R.O. Cem</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Elkridge, Howard, Maryland</i>              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McCully Funeral Homes</i>   |  |                                 |  |  |  | ADDRESS<br><i>Balto., Md., 21225<br/>237 E. Patapsco Ave.,</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 25 1984</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rodale</i>    |  |



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RECEIVED



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |
|---|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |   |  | 7 4 1 8 2 0 3  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOSEPH Francis NEUBECK</b>   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>7-4 1984</b>   |  | 2b HOUR<br><b>2:06PM</b>   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Caucasian</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>December 23, 1909</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>74</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N. CHARLES ST</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurseymen- Loudon Nurse</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Md. 21208</b>  |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Baltimore</b>  |  | 13c CITY OR TOWN<br><b>Pikesville</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>John James Neubeck</b>   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lillian Mae Ryland</b>  |  | 13e STREET ADDRESS / ZIP CODE<br><b>556 Sudbrook Lane Pikesville Md. 21208</b>   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>212-10-6531</b>   |  | 17 INFORMANT <b>Mrs. Evelyn Neubeck</b> ADDRESS <b>556 Sudbrook Lane Pikesville, Md. 21208</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE CHRONIC OBSTRUCTIVE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>PULMONARY DISEASE AND CONGESTIVE HEART FAILURE</b> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>7-4 1984 P.M.</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>7-3 1984</b> to <b>7-4 1984</b> , that (I) (we) last saw the deceased alive on <b>7-4 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b SIGNATURE<br><b>P. Crawford MD</b>  |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>7/4/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. P. CRAWFORD</b>   |  |   |  | 22e. ADDRESS<br><b>GBMC 6701 N. CHARLES ST, TOWSON MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>July 7 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Pikesville, Baltimore Maryland</b>                                       |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Loring Byers Funeral Directors, Inc.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>1111 5 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>La. Swindon-Randall</b>   |  |
| 8728 Liberty Road Randallstown, Maryland 21133  |  |   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84

18204

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |   |  |   |  |  |  |
|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Florence E. Neuner</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-29-84</b>  |  |   |  | 2b. HOUR<br><b>11 P M</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 12, 1898</b>   |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Valley Nursing &amp; Convalescent Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Spearman</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>2</b>  |  |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3626 Evergreen Avenue 21206</b>                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-32-5700</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. James R. Neuner 3626 Evergreen Ave 21206</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vasc. insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Generalized arterio-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>vascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>many years</b> |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>many years</b>  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9/18 19 68</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/18 19 68</b> to <b>7/29 19 84</b> , that (I) (we) lost<br>saw the deceased alive on <b>7/25 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Handwritten</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>         |  |   |  | 22c. DATE SIGNED<br><b>7/30/84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   |  | 23b. DATE<br><b>Aug. 1, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem</b>                  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc Baltimore, Md-</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 31 1984</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

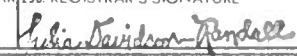
REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |   |                             |  |
|--|--|---|---|---|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY Jean NORTHERN</b>                                   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7/27/84</b> |   | 2b. HOUR<br><b>7:00P.M.</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-19-19</b>   |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                     |   | 8. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                             |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>                                    |  | 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b>  |                             |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Telephone Operator</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chessie</b>   |   | 12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE <b>Maryland</b> 12b. COUNTY <b>Baltimore</b> 12c. CITY OR TOWN <b>Baltimore</b>  |                             |  |
| 13a. STREET ADDRESS / ZIP CODE<br><b>2304 Echodale Ave. 21214</b>                                  |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13c. STREET ADDRESS / ZIP CODE<br><b>2304 Echodale Ave. 21214</b>   |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Oliver J. Whitehill</b>                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ellen Hawkins</b>                      |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |                             |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-01-2202</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Elbert E. Northern, Same as 13c</b>                              |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LUNG CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                             |  |

## MEDICAL CERTIFICATION

|  |  |  |  |
|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/06</b> , 19 <b>84</b> , to <b>7/27</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/27</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><br>DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. H. DE PAMPHILIS</b>  |  | 22e. ADDRESS<br><b>GBMC</b>  |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                          |  | 23b. DATE<br><b>7-31-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 30 1984</b>           |  | 25b. REGISTRAR'S SIGNATURE<br> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18206

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 7. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>IVA MAY NORWOOD  |  | MONTH DAY YEAR<br>July 12, 1984   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |
| Female  | White  | MONTH DAY YEAR<br>June 7 1895   | 89 YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |
| Penn.   | U.S.A.   |   | Baltimore County MD.   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |
| Baltimore   | Manor Care Rossville   |   | Homemaker  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. STREET ADDRESS  |
| Md.   | -  | Baltimore   | 4706 Shamrock Ave. 21206                                       |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   |   |  |
| FIRST MIDDLE LAST<br>John C. Kopp   | FIRST MIDDLE LAST<br>Grace French  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT   | ADDRESS  |
| no  | 213-01-1387-D  | Erma Armstrong (dghtr)  | same address   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular Accident<br>DUE TO, OR AS A CONSEQUENCE OF (b) Documented Cerebrovascular Impairment<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |   |  |
| O Cachexia O Senile Dementia  |  |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) this hospital attended the deceased from 6-27, 1983, to 7-12, 1984, that (I) <input checked="" type="checkbox"/> lost<br>saw the deceased alive on 7-12, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we did not view the body after death.) |  |   |  |
| 22b. SIGNATURE<br>Samuel Westrick   |  | 22c. DATE SIGNED<br>7-12-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL J. WESTRICK   |  | 22e. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |
| Burial  | 7/16/84  | Parkwood  | Baltimore Md.  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Schmuck Funeral Home  |  | 25. REC'D. BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VR A 15 (4) 9/74)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  | REG. NO. |  |
|---|--|---|--|--|--|---|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |  |  |  |   |  | 2b. HOUR   |  |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |  |  |  |   |  | 2b. HOUR   |  |          |  |
| FIRST MIDDLE LAST   |  | 7-19-1984   |  |  |  |   |  | 11:27 AM   |  |          |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR MONTHS DAYS                                    |  |          |  |
| Female  |  | White   |  | 4 26 1901  |  | 83 YRS.   |  |  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED NEVER MARRIED WIDOWED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |          |  |
| Baltimore   |  | U. S. A.  |  | NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | Baltimore Co. Md.   |  | MD.  |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |          |  |
| Kingsville  |  | 11208 Sheradale Dr.   |  | Housewife  |  | Home  |  |  |  |          |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |          |  |
| Md.   |  | Baltimore   |  | Kingsville   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 11208 Sheradale Dr. 21087                                      |  |          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |          |  |
| John  |  | Katherine   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 219-56-3621   |  | 11208 Sheradale Dr.  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |          |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |          |  |
| IMMEDIATE CAUSE (a)   |  |   |  | Multiple CVAs  |  |   |  | 3 mos  |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                      |  |   |  | (b) cerebral arteriosclerosis  |  |   |  | years  |  |          |  |
|   |  |   |  | (c)  |  |   |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |  |  |   |  |  |  |          |  |
| Parkinson's Disease   |  |   |  |  |  |   |  |  |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  | 22a. I certify that (I) (this hospital) attended the deceased from  |  | 22b. SIGNATURE   |  |          |  |
| OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF FIRST, NOTIFY MEDICAL EXAMINER)   |  | P.M. 19   |  |  |  | 19 84, to 7/19, 19 84, to   |  | Phyllis K. Pullen MD   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  | 22c. DATE SIGNED  |  | 7/20/84  |  |          |  |
|   |  |   |  |  |  |   |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from  |  | 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                               |  | 22e. ADDRESS   |  |          |  |
| 19 84, to 7/19, 19 84, to   |  | Phyllis K. Pullen MD  |  | 7/20/84  |  | Phyllis K. Pullen   |  | 2807 Jerusalem Rd, Kingsville, Md                              |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                      |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                             |  |          |  |
|   |  |   |  | Burial   |  | 7-23-1984   |  | Gardess of Faith   |  |          |  |
|   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | 23e. DATE REC'D. BY REGISTRAR                                       |  | 23f. REGISTRAR'S SIGNATURE                                     |  |          |  |
|   |  |   |  | Roxville Baltimore Md.   |  | JUL 23 1984   |  | Julia Davidson-Randall   |  |          |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. DATE   |  | 24c. NAME OF CEMETERY OR CREMATORY   |  | 24d. LOCATION CITY OR TOWN COUNTY STATE                             |  | 24e. DATE REC'D. BY REGISTRAR                                  |  |          |  |
| E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087  |  | 7-23-1984   |  | Gardess of Faith   |  | Roxville Baltimore Md.  |  | JUL 23 1984  |  |          |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

The medical examiner must be notified at once.

| HELEN M. NOWAKOWSKI  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 4 1 8 2 0 8  |  |                                |  |
|--|--|---|--|--|--|--|--|--|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |                                |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>HELEN M. NOWAKOWSKI   |  |   |  | 2a DATE OF DEATH<br>7 14 84 11:15 am   |  |  |  |  |  |                                |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>8 17 04   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. County MD.                                       |  |  |  |                                |  |
| 10 CITY OR TOWN OF DEATH<br>ESSEX  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Riverview Nursing Ctr. Inc. |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PIANIST  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>ENTERTAIN  |  |  |  |                                |  |
| 13a STATE<br>MD  |  | 13b COUNTY<br>---   |  | 13c CITY OR TOWN<br>BALTO  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>130 N. ELLWOOD 21224   |  |                                |  |
| 14 FATHER'S NAME<br>Steve Stanakowski  |  | 15 MOTHER'S MAIDEN NAME<br>Carrie   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b SOCIAL SECURITY NO.<br>212-34-7275   |  | 17 INFORMANT ADDRESS<br>Leonard Kedzierski 1130 N Elwood Ave   |  |                                |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for each part.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Melastatic Carcinoma of breast<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>one year |  |   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                       |  |  |  |  |  |                                |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |                                |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                                |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                                |  |
| 22a I certify that (I) (this hospital) attended the deceased from Jan. 26, 1984 to July 14, 1984, that (I) (we) lost the deceased alive on July 12, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.  |  |   |  |  |  |  |  |  |  |                                |  |
| 22b SIGNATURE<br>Morris Rainess MD   |  |   |  | DEGREE<br>MD   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br>7-14-84     |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>MORRIS RAINESS, MD   |  |   |  | 22e ADDRESS<br>1105 W. EASTERN AVE. Balto MD 21224   |  |  |  |  |  |                                |  |
| 23a BIRTH, CREMATION, REMOVAL (SPECIFY)<br>CREMATION   |  | 23b DATE<br>7/16/1984   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Westview  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO BALTO MD                                    |  |  |  |                                |  |
| 24 FUNERAL DIRECTOR<br>J. J. J. 1211 Cosaca Ave  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br>JUL 16 1984  |  | 25b REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendall  |  |  |  |                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted on the back of this certificate.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Peyton G. Oakes</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 13, 1984</b>                                     |  | 2b. HOUR<br>M<br><b>7</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 28 1913</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>71</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex 21221</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH INSTITUTION, GIVE STREET & CITY)<br><b>322 Lorraine Ave.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK (FORMER OR WORKING LIFE))<br><b>Machinist</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Aircraft</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Essex</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>322 Lorraine Ave. 21221</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Munsey Oakes</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Graves</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>   |  | 17. INFORMANT<br><b>Evelyn Oakes, Wife</b>  |  | ADDRESS<br><b>Same</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Congestive heart failure, history of ventricular tachycardia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>SEPT</u> , 19 <u>82</u> , to <u>JULY</u> , 19 <u>84</u> , that (2) (we) last saw the deceased alive on <u>JUNE 25</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Richard A. Josephson</i>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>7/13/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard A. Josephson</b>   |  |   |  | 22e. ADDRESS<br><b>Francis Scott Key Medical Center</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/16/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>  |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Baltimore, Md.</b>                           |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Edward Z. Brudzinski</i>  |  |   |  | 24b. ADDRESS<br><b>PA 1407 Old Eastern Ave</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Randall</i>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |   |  |   |   |  |  |
|---|--|---|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LILLIAN C. O'BRIEN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 23 1984</b>                |   | 2b. HOUR<br><b>11:55A<sub>M</sub></b>   |  |   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 18, 1889</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Ruxton</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>  |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>29 Dunvale Road 21204</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert S. Parker</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Letitia Blackburn</b> |   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-09-6496</b>                            |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Richard Jones 425 Dumbarton Road 21212</b>        |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>SENILITY</b>  |  |   |   |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)        |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) not view the body after death. |  |   |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Celilar E. Parra</b>   |  |   |   |   |   | DEGREE <b>DR. KEEB</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>7/23/84</b>                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Celilar E. Parra</b>  |  |   | 22e. ADDRESS<br><b>7122 Harford Road</b>                                  |   |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>7-26-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Md.</b>                    |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 24 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO. |  |
|---|--|--|--|---|--|---|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>IRVING Charles Edward O'CONNOR</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 4 1984</b> |   |  | 2b. HOUR<br>MIN<br><b>11;22A</b>   |  |          |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 1, 1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>                                |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N. CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Pressman Baltimore Sun</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4525 Arabia Ave. 21214</b>  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward W. O'Connor</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marguerite Schilling</b>  |  |   |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-03-2768</b>   |  | 17. INFORMANT<br><b>Ethel M. O'Connor</b>   |  |   |  | ADDRESS<br><b>4525 Arabia Ave. 21214</b>   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>LUNG CARCINOMA WITH METASTASES</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |   |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-20</b> 19 <b>84</b> , to <b>7-4</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7-4</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                            |  |  |  |   |  |   |  |  |  |          |  |
| 22b. SIGNATURE<br><b>Loliane Pappas MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>7/4/84</b>  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DIANE PAPPAS MD</b>   |  |  |  | 22e. ADDRESS<br><b>GBMC 6701 N. CHARLES ST., TOWSON</b>   |  |   |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>July 7, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                          |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 6 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                       |  |  |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8418212   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Rev. Thomas E. O'Connor  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 11, 1984  |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 5, 1909  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>75  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Canada  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>601 Maiden Choice Lane |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Roman Catholic  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Priest Ret.  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Catonsville   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Joseph O'Connor   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Agnes Foley   |  | 13e. STREET ADDRESS / ZIP CODE<br>603 Maiden Choice Lane 21228   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>219-60-8456  |  | 17. INFORMANT ADDRESS<br>Joseph Reynolds 5408 Roland Ave. 21210  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Prostate</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>8:10 PM 7 11 1984  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>711   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>711 Catonsville, Md.   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/11/84, to 7/11/84, that (I) (we) last saw the deceased alive on 7/11/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Ravendhran</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7/13/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Natrassan Ravendhran, M.D.  |  |  |  | 22e. ADDRESS<br>St. Agnes Medical Center   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>July 16, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sulpician Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Catonsville, Md.   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>Leonard J. Ruck, Inc. Baltimore, Md.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JUL 16 1984 <i>John Davidson</i>   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

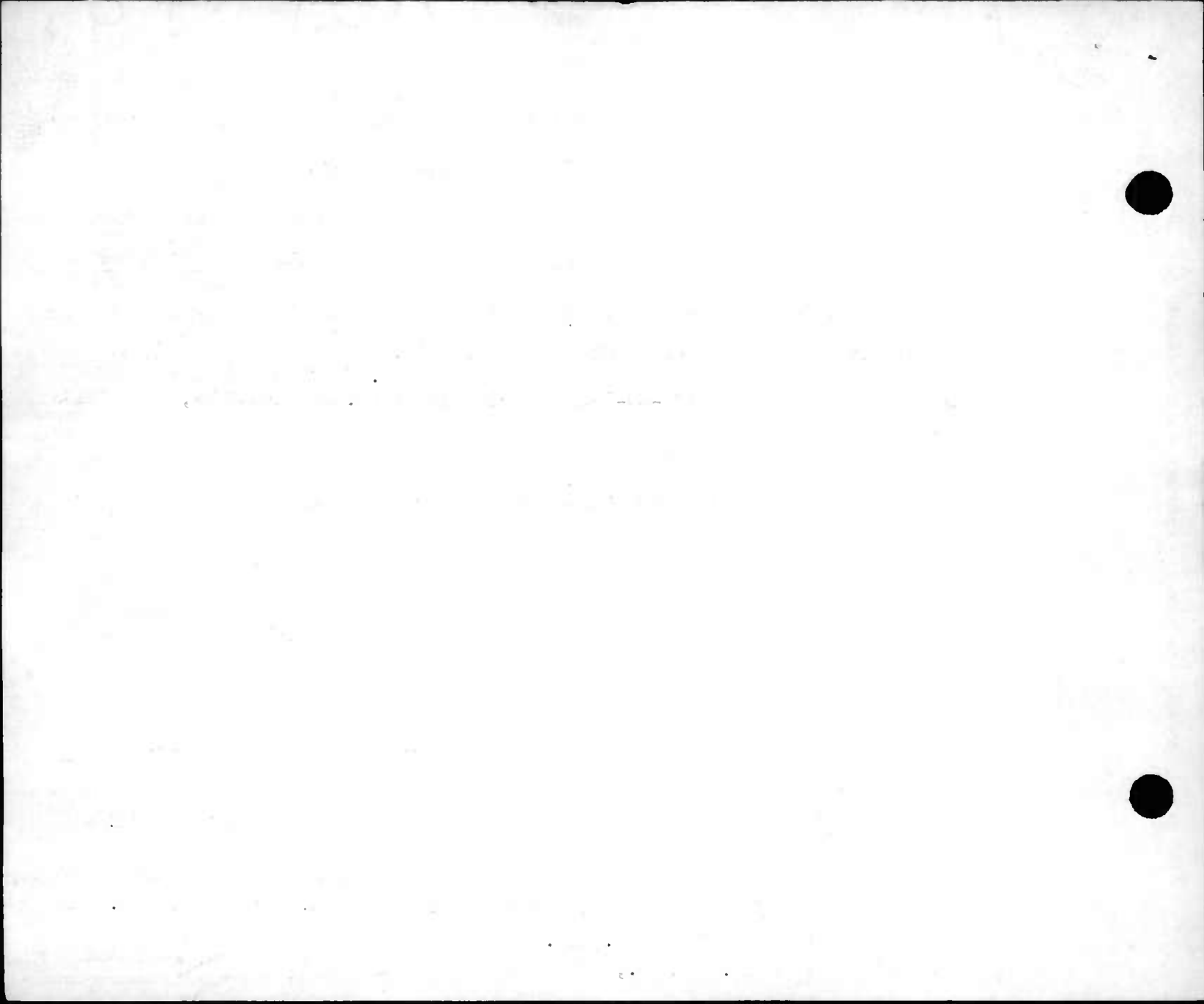
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|   |  |  |  |   |  |   |  |  |  |  |  |                       |  |
|---|--|--|--|---|--|---|--|--|--|--|--|-----------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>MAY  |  | MIDDLE<br>OETTINGER   |  | LAST<br>OETTINGER  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7-25-84 |  | 2b. HOUR<br>6:10 P.M. |  |
| 3. SEX<br>male  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 20 1902   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. UNDER 24 HRS<br>HOURS MIN.                  |  |                       |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GERMANY   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |  |  |  |                       |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hosp |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MACHINIST   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MACHINES   |  |  |  |  |  |                       |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Randallstown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3735 Trent Rd. 21133   |  |  |  |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ABRAHAM OETTINGER   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CHARLOTTE MARKS   |  |   |  |   |  |  |  |  |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO.<br>124-09-7629  |  | 17. INFORMANT<br>MRS. KLARA OETTINGER   |  | 3735 TRENT RD. RANDALLSTOWN, MD   |  | 21133  |  |  |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |  |  |  |  |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |   |  |   |  |  |  |  |  |                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |                       |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-23 1984 to 7-25 1984, that (I) (we) last saw the deceased alive on 7-25 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |                       |  |
| 22b. SIGNATURE<br>Allen J. Chircus M.D.   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>7/25/84   |  |  |  |  |  |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Allen J. Chircus M.D.  |  | 22e. ADDRESS<br>32504 Hill Rd Apt 15 Pikesville 21208  |  |   |  |   |  |  |  |  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>7/26/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHEVRA AHAVAS CHESED  |  | 23d. LOCATION<br>RANDALLSTOWN BALTO. MD.  |  |  |  |  |  |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.  |  | ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 1 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Jha Davidson-Randall  |  |  |  |  |  |                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

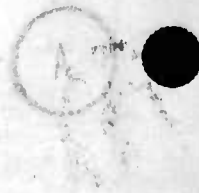
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PAULINE</b>  |  | FIRST <b>PAULINE</b> MIDDLE<br><b>PAULINE</b>   |  | LAST <b>OLSZEWSKI</b><br><b>OLSZEWSKI</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 26 1984</b>   |   | 2b. HOUR<br>M<br><b>1 35</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 23, 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BAITO. COUNTY</b> MD  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Lutherville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>835 Jamieson Rd. 21093</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Simon Urbanski</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Kuc</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN); (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>214-22-2355</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Rita Dorl -2150 Suburban Greens Dr. 21093</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute lymphoblastic leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/20</b> , 19 <b>84</b> , to <b>7/26</b> , 19 <b>84</b> , that (we) lost<br>saw the deceased alive on <b>7/26</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (a) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Lester A. Wall, Jr.</b>   |  |   | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7/26/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LESTER A. WALL, JR., M.D.</b>  |  |   | 22e. ADDRESS<br><b>7620 York Rd Towson MD 21204</b>                    |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>7-30-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck-Jawson</b>   |  |   | 1050 York Rd.<br>ADDRESS<br><b>Towson, Md.</b>                         |   | 25a. DATE REC'D. BY REGISTRAR<br><b>204 JUL 30 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>              |  |  |

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Simon  
Urbanville  
Mary  
Lutherville, Md.  
Rita Dori - 2150 Suburban Greens Dr. 21093  
214-23-2355  
Lutherville  
Baltimore  
Towson  
Maryland  
U.S.A.  
White  
January 23, 1903  
81  
Owens  
Lutherville, Md.  
21093

Postal  
7-30-84  
Holy Rosary  
Baltimore  
Maryland  
1050 York Rd.  
Towson, Md. 21204 JUL 30 1984



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, LEAVE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DP  
DHMH-17  
(VR 115 ME (5))  
15M 7/76

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                  |                |   |  |   |  |   |               |                  |  |   |  |   |   |  |  |  |  |
|--|--|------------------|----------------|---|--|---|--|---|---------------|------------------|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>RUBEN |   |  | MIDDLE<br>ORMAN                               |  |   | LAST<br>ORMAN |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 7/16 19 84 4:53 PM     |  |   | 2b. DATE OF DEATH<br>MONTH DAY YEAR HOUR<br>JULY 15, 19 84 5 A.M. |  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCT. 26, 1923   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>60 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |               | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD<br>JULY 15, 19 84 5 A.M.   |  |   | 2d. HOUR  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |                  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  |                  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GENERAL HOSPITAL |  |   |  |   |               |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESMAN                       |  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL                |  |  |  |
| 13a. STATE<br>MARYLAND   |  |                  |                | 13b. COUNTY<br>BALTIMORE  |  |   |  | 13c. CITY OR TOWN<br>BALTIMORE  |               |                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   | 13e. STREET ADDRESS<br>4527 MARYKNOLL RD. 21208            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH ORMAN   |  |                  |                |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SADIE MAX  |               |                  |  |   |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |  |                  |                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII-ARMY 215-14-0306  |  |   |  | 17. INFORMANT MRS. CHARLOTTE ORMAN<br>4527 MARYKNOLL RD. BALTO., MD 21208   |               |                  |  |   |  |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u>    |  |                  |                |   |  |   |  |   |               |                  |  |   |  |   |   |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |                |   |  |   |  |   |               |                  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |               |                  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |               |                  |  |   |  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                  |                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |               |                  |  |   |  |   |   |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                |   |  |   |  |   |               |                  |  |   |  |   |   |  |  |  |  |
| ACTUAL SIGNATURE <u>Stanley Z. Felsenberg</u>  |  |                  |                | TITLE (SPECIFY)<br>M.D. <u>Deputy</u>   |  |   |  | MEDICAL EXAMINER  |               |                  |  | DATE SIGNED <u>7/15/84</u>  |  |   |   |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>DR. STANLEY Z. FELSENBERG  |  |                  |                | ADDRESS<br><u>11 E. Chase St. 21202</u>   |  |   |  |   |               |                  |  |   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |                  |                | 23b. DATE<br>7/16/84  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH EL MEM. PARK   |               |                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>RANDALLSTOWN BALTO. MD                            |  |   |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215   |  |                  |                |   |  |   |  |   |               |                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 17 1984  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u> |  |  |  |

14/10/19



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 4 1 8 2 1 6

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |  |  |   |                           |  |  |
|---|--|--|--|---|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM J. OTTER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 6 84</b> |   | 2b. HOUR<br><b>2035 M</b> |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 25, 1913</b>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CO.</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CAB. MAKER</b>   |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MASTERCRAFT</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>PARKVILLE</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PHILLIP J. OTTER</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BERTHA M. JOHNSON</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |                           | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W.J. 216 03 0095</b>                                       |  |
| 17. INFORMANT<br><b>FAMILY RECORDS</b>  |  | ADDRESS<br><b>7909 BELVERLY AVE.</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CHRONIC MYOPATHY, ISCHEMIC</b> |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>YRS</b>   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |                           |  |  |
|   |  | (c)  |  | DUE TO, OR AS A CONSEQUENCE OF  |                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |                           |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) _____ the body after death. |  |  |  |   |                           |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                   |                           | 22c. DATE SIGNED<br><b>7-6-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD D. [Signature]</b>  |  | 22e. ADDRESS<br><b>7600 OSLER DR 21204</b>   |  |   |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>JULY 10, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MARYLAND MON. PK.</b>  |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPL OF MEMORIES HARFORD RO.</b>  |  | ADDRESS<br><b>8800</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 11 1984</b>   |                           | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general practitioner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 18217

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SPENCER S. OVERTON</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 15 1984</b>                           |   | 2b. HOUR<br>MIN.<br><b>8<sup>45</sup> A</b>  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV 3 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO COUNTY</b> MD.                                 |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6722 EDWARD AVE</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINIST</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BLOG. CONT.</b>  |
| 13a. STATE<br><b>MD</b>   |   | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>WOODLAWN</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>6722 EDWARD AVE</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES OVERTON</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DAISY JONES</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-34-4214</b>   |  | 17. INFORMANT<br><b>OVERTON</b> ADDRESS<br><b>6722 EDWARD AVE</b>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Arteriosclerotic Cardiovascular Disease</b>  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 72</b> , 19 <b>84</b> , to <b>July 15</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>July 14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Ross Z. Picurpon</b>   |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>July 15, 1984</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ross Z. Picurpon M.D.</b>   |   | 22e. ADDRESS<br><b>8415 Bellona Lane 21204</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>REMARKS<br><b>CREMATION</b>  |   | 23b. DATE<br><b>7/17/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW MEM.</b>                           |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO BALTO MD</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WEBER FUNERAL HOME EMMONDSON AVE</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 19 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 2 1 8

1- FOR  
STATE  
REGISTRAR

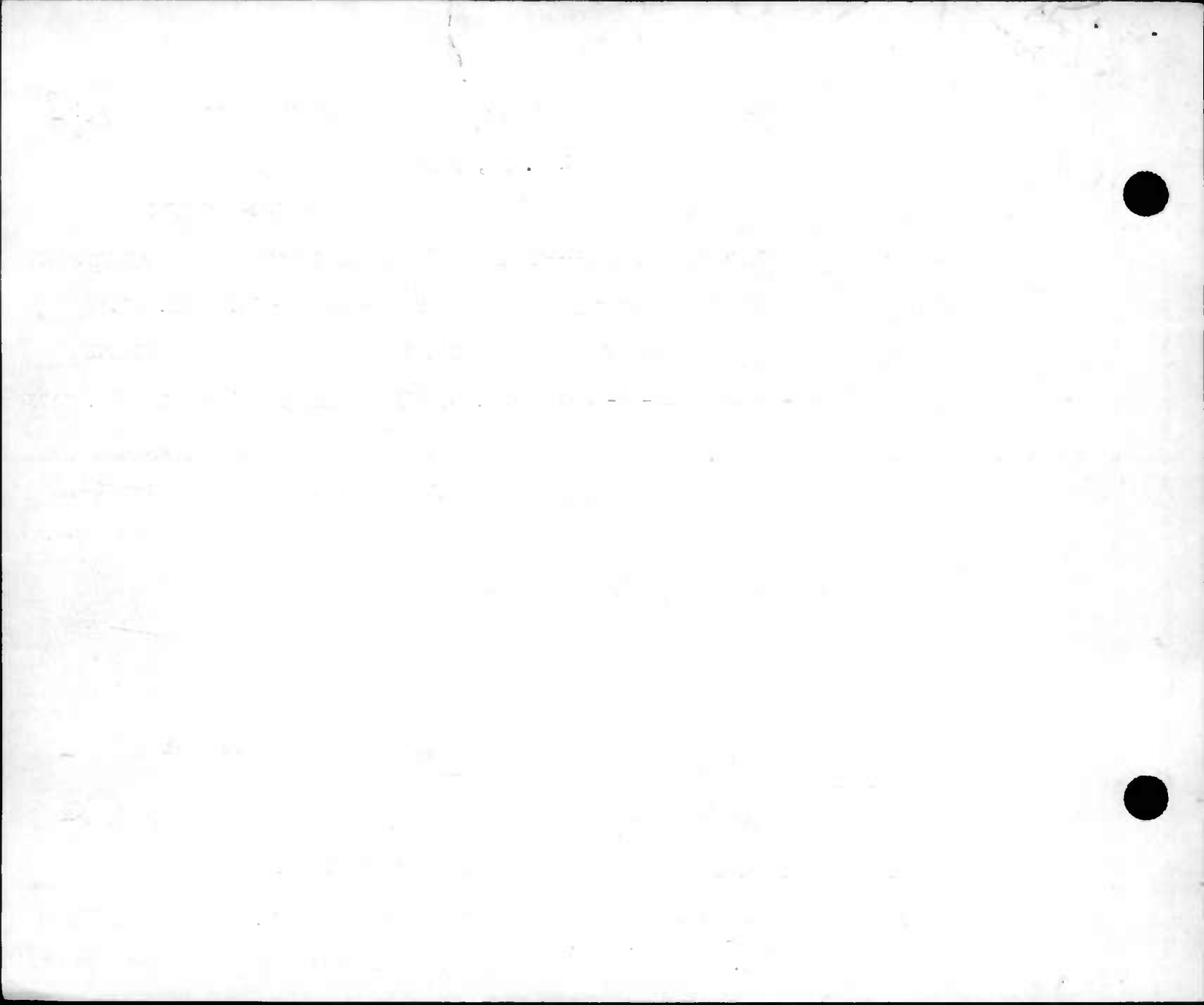
REG. NO.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM PASTER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 16, 1984</b>                         |   | 2b. HOUR<br><b>12:17 AM</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 14, 1916</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE COUNTY MD</b>                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>ROSEDALE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ENGINEER</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MAINTENANCE</b>   |   |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HYMAN PASTER</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FANNIE SIEGEL</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WWII-MARINES 216-03-6562</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>MRS. SYLVIA PASTER 4559 BENNERTON DR. 21236</b>                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis</b> |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>10 years</b><br><b>10+ years</b>                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Inflammatory Bowel Disease, Diabetes</b>   |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7 10 84</b><br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) <del>the hospital</del> attended the deceased from <b>7 10 84</b> to <b>July 16, 1984</b> that (1) <del>the</del> saw the deceased alive on <b>7 10 84</b> and that in (my) <del>low</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>was</del> (did) not view the body after death.                                    |  |   |   |   |   |
| 22b. SIGNATURE<br><b>Keith A. Manley</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>7-16-84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. KEITH A. MANLEY</b>   |  | 22e. ADDRESS<br><b>1818 POT SPRINGS RD.</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>7/ 17/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMENS CIRCLE CEM</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 23 1984</b>                                 |   |   |
|   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Randall</b>                          |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 4 18219

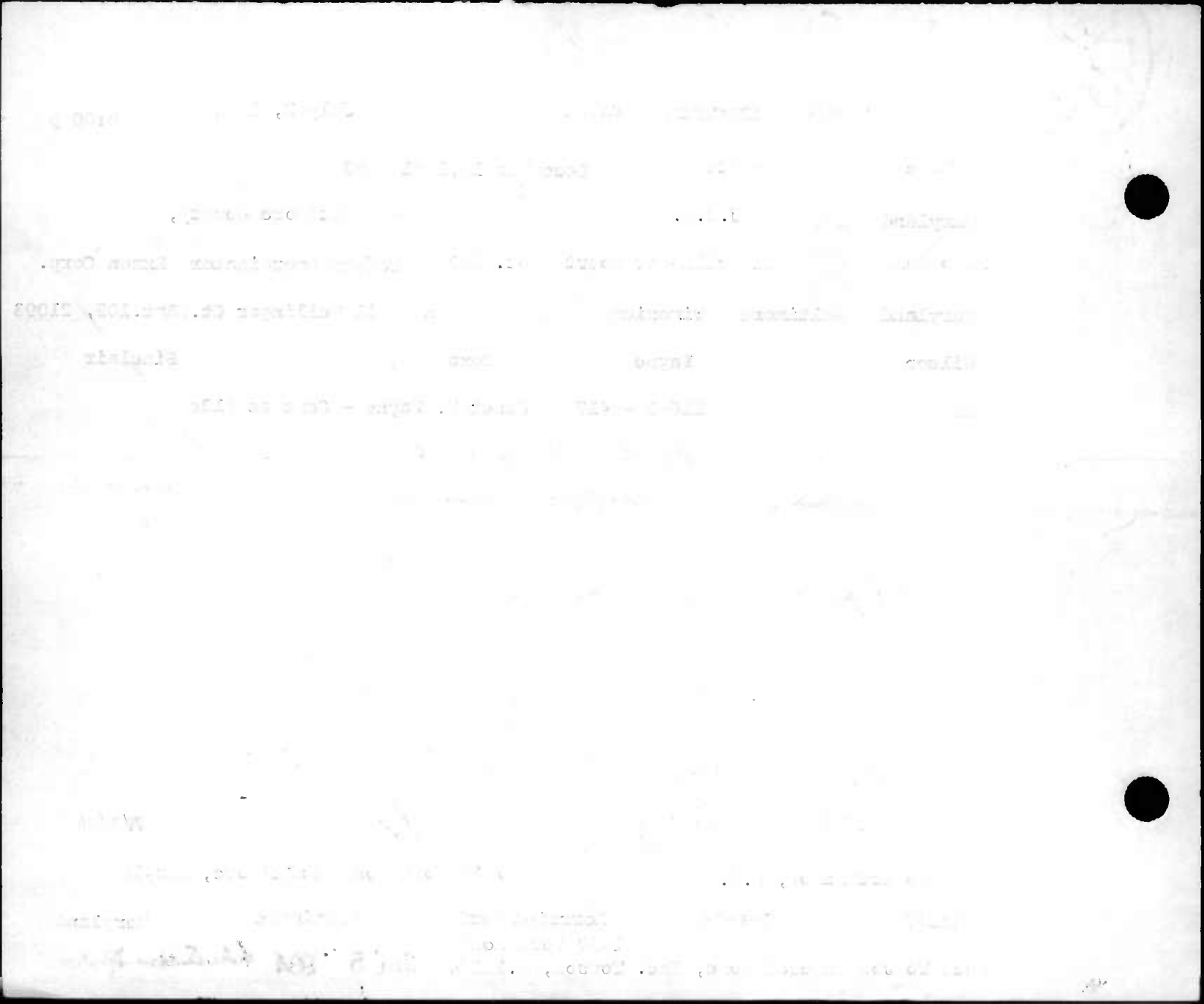
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|--|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>DONALD SINCLAIR PAYNE</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 2, 1984</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><b>December 12, 1901</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>82</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Timonium</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11 Mullingar Court Apt. 102</b> |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Safety Coordinator</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Exxon Corp.</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  |
| 13c. CITY OR TOWN<br><b>Timonium</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>11 Mullingar Ct., Apt. 102, 21093</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Wilson Payne</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Cora Sinclair</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-9417</b>   |  |
| 17. INFORMANT<br><b>Janet F. Payne - Same as #13e</b>  |  | ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Melanotic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prostate Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Retenopercutaneous Carcinoid Tumor</u>   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/29</u> 19 <u>84</u> to <u>Present</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6/29</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                          |  |  |  |
| 22b. SIGNATURE<br><u>Robert Mahon</u>  |  | 22c. DATE SIGNED<br><b>7/3/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Mahon, M.D.</b>   |  | 22e. ADDRESS<br><b>7620 York Road Baltimore, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-6-84</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 5 1984</b>   |  |
| ADDRESS<br><b>1050 York Road Towson, Md. 21204</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Lelia Gordon Ruckell</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elsie Phelps Pearce</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 16 1984</b> |   |  | 2b. HOUR<br><b>11:30</b>  |  | P  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 16 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. Co.</b> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Monkton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2334 Sheppard Rd., 21111</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Monkton</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2334 Sheppard Rd., 21111</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Phelps</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lilly Martin</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-46-4984</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. John H. Pearce, Jr., Butler Rd., 21023</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                     |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 HOURS</b><br><b>5 YEARS</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CEREBELLAR DEGENERATION</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 1982</b> to <b>16 July 1984</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>5 June 1984</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>J. Dixon Hills</b>  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>18 July 84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Dixon Hills, M. D.</b>  |  |  |  | 22e. ADDRESS<br><b>3501 St. Paul St., Balto., Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/19/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. James Epis. Ch. Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Monkton Balto. Md.</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Martin D. Lawson, 10 W. Padonia Rd. 21093</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 20 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |  |  |  |

MEDICAL CERTIFICATION

08:14:30 10/13/1930

William  
L. Williams  
21-10-30  
2 years  
2 years

George H. Williams

George H. Williams  
21-10-30  
2 years  
2 years

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE SUPERVISOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |   |  |  |  | REG. NO. 18221  |  |
|---|--|----------------------|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE O. PEEDE</b>   |  |                      |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>7/1/84</b> |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH MONTH <b>11</b> DAY <b>2</b> YEAR <b>1909</b>   |  | 6. AGE (IN YEARS) LAST BIRTHDAY <b>74</b> YRS.                                      |  | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   |  | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD   |  |
| 10. CITY OR TOWN OF DEATH <b>Dundalk</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1728 Stengel Road</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                      |  |  |  |   |  |  |  |   |  |
| 13a. STATE <b>Maryland</b>  |  |                      |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Dundalk</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>1728 Stengel Road 21222</b>  |  |
| 14. FATHER'S NAME FIRST <b>Oliver</b> MIDDLE <b>J.K.</b> LAST <b>Peed</b>   |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Julia</b> MIDDLE <b>Capton</b> LAST <b>Capton</b> |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>213-07-0741</b>  |  |   |  | 17. INFORMANT ADDRESS <b>Helen A. Peede Balto. MD 21222</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>Congestive Cardiac Failure</b> (b) <b>Chronic Pulmonary Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF <b>Chronic Pulmonary Emphysema</b> (c) <b>Chronic Pulmonary Emphysema</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>? due to Asbestosis</b> |  |                      |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |  |                      |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>K.S. AHLUWALIA</b>  |  |                      |  | TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>7/2/84</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>K.S. AHLUWALIA</b>   |  |                      |  | ADDRESS <b>2112 Dundalk Av Balto 21222</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      |  | 23b. DATE <b>7/5/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>                         |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>   |  |                      |  | 25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1984</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |  |                                       |  |   |  |
|---|--|---|---|---|---|--|---------------------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mary PEIZIK</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 27, 1984</b> |   |   | 2b. HOUR<br><b>1:30<sup>P</sup> M</b>  |                                       |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc.</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 14 1898</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS                                     |                                       | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>86</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Poland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                  |                                       |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. County</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF LIFE)<br><b>Homemaker</b>         |                                       | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |   |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Mikulski</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Kwoka</b> |  |                                       |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-5189D</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>E. Ward Peizik - 6417 Danville Ave, 21224</b>  |   |  |                                       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF BLADDER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |   |   |   |  |                                       |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>11a</b>   |  |   |   |   |   |  |                                       |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |                                       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                                       |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 25</b> , 19 <b>84</b> , to <b>JULY 27</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>JULY 27</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) (not) visit the body after death. |  |   |   |   |   |  |                                       |  |   |  |
| 22b. SIGNATURE<br><b>Robert J. Tretola M.D.</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  |                                       | 22c. DATE SIGNED<br><b>JULY 27, 1984</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. TRETOLA</b>  |  |   |   | 22e. ADDRESS<br><b>9000 FRANKLIN SQUARE DR, 21237</b>   |   |  |                                       |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>07/31/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Mary</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                  |                                       |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Dabrowski</b>   |  |   |   | ADDRESS<br><b>1005 Dundalk Avenue 21224</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 2 1984</b>                                   |                                       |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





|                |                       |                             |
|----------------|-----------------------|-----------------------------|
| Female         | 07 10 5084 88         |                             |
| Poland         | 0.3.4                 | x                           |
| Poland, County | Franklin Square Hosp. | 0.3.4                       |
| Maryland       | Baltimore             | x                           |
| Paul           | Nikolski              | Katherine                   |
| No             | 213-07-21809          | 213-07-21809 - 213-07-21809 |

*[Faint, mostly illegible text and markings in the middle section of the document.]*

Walter Dabrowski - 1007 Dunbar Avenue 2124  
07/31/84  
Secured Means of Entry  
Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |  |  |   |  |
|---|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Joann PENIZA</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 5 1984</b> |   |  | 2b. HOUR<br>p <b>2:05</b> M  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-19-31</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>52</b>   |  | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN.<br><b>2:05</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |  |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8008 Del Haven Rd. 21222</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Troy Williams</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Rose</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-28-4171</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Jose Peniza. 8008 Del Haven Rd. 21222</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS PERITONITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>  |  |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 11</b> , 19 <b>84</b> , to <b>JULY 5</b> , 19 <b>84</b> that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>JULY 5</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>M.E. Zeitounch</b>   |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7-5-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. ZEITOUNEH</b>   |  |  |   | 22e. ADDRESS<br><b>9000 FRANKLIN SQUARE DRIVE 21237</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>7-7-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph N. Zannino, 263 S. Conkling Street</b>  |  |  |   |   |  | 25. DATE REC'D. BY REGISTRAR <b>JUL 9 1984</b> REGISTRAR'S SIGNATURE <b>J. H. Anderson</b>   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE D. LAST PERKINS   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 11 84  |   | 2b. HOUR<br>4:21 AM  |   |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 4 09  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                                     |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County                       |   |
| 10. CITY OR TOWN OF DEATH<br>Towson  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St Joseph Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Teacher             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. County  |
| 13a. STATE<br>MD   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Towson   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS & ZIP CODE<br>331 Dixie Drive 21204                        |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph M. Dignan   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Bowling   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>218-32 9984   |   | 17. INFORMANT<br>George H. Perkins - Same as #13e                              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) (b) (c)<br>(a) Intracerebral Hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertension<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1d   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |   |  |   |
| 22b. SIGNATURE<br><i>[Signature]</i>   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>7/11/84  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>7-14-84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium, Baltimore, Maryland   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.   |   | ADDRESS<br>1050 York Rd.<br>Towson, Md 21204  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 12 1984                                   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Printed

7-14-84

Dulaney Valley

1050 York Rd.

Rock Towson Funeral Home, Inc. Towson, MD 21204

JUL 12 1984

Timonium, Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 2 2 5

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mrs. Edith Peterson</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 1 1984</b>   |  |   |  | 2b. HOUR<br><b>1915</b> M   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 8 1895</b>  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore City</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5644C Woodmont Ave.</b> 21239   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Carlson</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hilma (Wahlberg) Carlson</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-01-6892</b>   |  | 17. INFORMANT'S NAME<br><b>Mr. Elfo Peterson</b>  |  |   |  | 17. ADDRESS<br><b>6811 Campfield Rd. Baltimore Maryland</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>New onset CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |   |  |   |  |   |  |
| MEDICAL CERTIFICATION  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> , 19 <b>84</b> , to <b>7/1</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/1</b> , 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (and not) view the body after death.                               |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Jeffrey Chircus MD</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br><b>7-1-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeffrey Chircus MD</b>   |  | 22e. ADDRESS<br><b>12426 Greenspring Ave Owings Mills Md</b>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7-8-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville Baltimore Maryland</b>               |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>  |  |   |  | 24. ADDRESS<br><b>8728 Liberty Road Randallstown, Maryland 21133</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Jackson</b>   |  |





TO HOSPITAL-OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |                                       |  |
|--|--|--|---|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LOUIS JOSEPH PFANDTNER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>07 13 84</b>                  |  | 2b. HOUR<br><b>11:45 PM</b>           |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>Cauc.</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 31 15</b>                          |                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b><br>YRS MONTHS DAYS                |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>OWSON, MD.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.            |                                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELECTRONIC ENG.</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BENDIX</b>                      |  |                                       |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATHERINE GIESE</b> |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>WILLIAM FISHER 8334 DALESFORD RD. 21234</b>     |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>ALCOHOLIC LIVER DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>MALNUTRITION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |  |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.<br><b>ALCOHOLIC ENCEPHALOPATHY</b>   |  |  |   |  |                                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/26/84</b> , 19 <b>84</b> , to <b>7/13</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |   |  |                                       |  |
| 22b. SIGNATURE<br><b>Todd H. Hillman, MD.</b>  |  |  |   | 22c. DATE SIGNED<br><b>7/14/84</b>   |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TODD H. HILLMAN, MD.</b>   |  |  |   | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>                                |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>JULY 17, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DULANEY VALLEY</b>                    |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>STEWART &amp; MOWEN CO. BALTIMORE, MD.</b>  |  | 24b. ADDRESS<br><b>108 W. NORTH AVE.</b>   |   | 24c. DATE REC'D. BY REGISTRAR<br><b>JUL 18 1984</b>                            |                                       |  |
| 24d. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>   |  | 24e. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>   |   |  |                                       |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   | REG. NO.  |  |
|--|--|---|---|---|--|
| 1 - STATE REGISTRAR  |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA H PHILLIPS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>JULY 14, 1984</b>  |   | 2b. HOUR<br><b>8:00 A.M.</b>                                     |
| 3. SEX<br><b>femlae</b>  | 4. RACE<br><b>black</b>                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3 9 1916</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68 YRS.</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore county</b> MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b>                               |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                            |  |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br><b>21223 Avenue</b>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clem Dowdy</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva Dowdy</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Brookville Md</b><br><b>Frances Diallo 3351 Gold Mine Rd</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ArTeriolar Nephrosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 + years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Jaundice</b><br><b>Uremia; Heart Failure; Septicemia/Septic Arthritis; Obstructive</b>   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 19 84</b> , to <b>July 14, 19 84</b> , that (we) lost saw the deceased alive on <b>July 14, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (h) (we) (did) (did not) view the body after death.                     |  |   |   |   |  |
| 22b. SIGNATURE<br><b>John F. Gustafson</b>   |  | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>July 14, 1984</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John F. Gustafson, M.D.</b>  |  | 22e. ADDRESS<br><b>5480 Wisconsin Avenue; Chevy Chase Md. 20815</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/18/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cemetery</b>                                |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Southhill</b>  |  | COUNTY<br><b>Va.</b>  |   | STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. March F/H 1101 E. North Ave</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>11/11 16 1984</b>   |   |  |
| ADDRESS<br><b>1101 E. North Ave</b>  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>W. C. March</b>  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 8 2 2 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |                  |   |  |  |  |                                |  |
|--|--|---|---|---|------------------|---|--|--|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>XXXXXX HAROLD PRESS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 4, 1984 |   | 2b. HOUR<br>7 AM |   |  |  |  |                                |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEBRUARY 1, 1912  |                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3617 YENMAR LANE, APT. 1-B (21207) |   |   |                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PRINTER                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SUNPAPERS   |  |                                |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |   | 13c. CITY OR TOWN<br>BALTIMORE  |                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3617 YENMAR LANE, APT. 1-B (21207)   |  |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JACOB PRESS  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>GERTRUDE HILKOWITZ   |                  |   |  |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-07-3357  |   | 17. INFORMANT<br>ADDRESS<br>MRS. SYLVIA PRESS 3617 YENMAR LANE, APT. 1-B (21207)  |                  |   |  |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ATHEROSCLEROTIC HEART DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |   |                  |   |  |  |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>CORONARY ARTERY BYPASS GRAFTING - 1980; CHRONIC PULMONARY DISEASE</u>   |  |   |   |   |                  |   |  |  |  |                                |  |
| 19a. DATE OF OPERATION<br><u>11/28/80</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                  |   |  |  |  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                  |   |  |  |  |                                |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>7/3/84</u> to <u>7/4/84</u> , that (i) (we) last saw the deceased alive on <u>7/3/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.  |  |   |   |   |                  |   |  |  |  |                                |  |
| 22b. SIGNATURE<br><u>Bernard Rubin</u>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                  |   |  | 22c. DATE SIGNED<br>7/5/84   |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. BERNARD RUBIN   |  |   |   | 22e. ADDRESS<br>3502 CROYDON RD. (21207)  |                  |   |  |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>7/6/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW FRIENDSHIP CEM   |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |  |  |  |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215   |  |   |   |   |                  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 10 1984  |  |  |  |                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8418229

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROSE PROMUTICO</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 2, 1984</b>   |  | 2b. HOUR<br><b>6:30A M</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 18, 1895</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Italy</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7631 Johnnycake Road</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>(UNKNOWN)</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosemarie (unknown)</b>  |  | 13d. STREET ADDRESS / ZIP CODE<br><b>7631 Johnnycake Road 21207</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-05-8838D</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Rocci J. Promutico - Baltimore, Md. 7629 Johnnycake Road 21207</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertension - Arterio-sclerotic Vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/20</b> , 19 <b>78</b> , to <b>7/2</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>6/1/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                       |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Joseph R. Liberto</b>  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>7/3/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph R. Liberto M.D.</b>  |  | 22e. ADDRESS<br><b>3508 BAYVIEW ST - Baltimore, Md 21224</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/5/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll Md.</b>   |  | 23e. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b>   |  |   |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>   |  | 24b. ADDRESS<br><b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 6 1984</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Borden</b>  |  |  |  |   |  |

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FILED  
PCX COLLOR

JUL 5 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FLORYNE R. PUMPIAN</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-5-84</b>  |  | 2b. HOUR<br><b>4:30 PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 29, 1905</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 1 YEAR<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |  | 13a. STREET ADDRESS / ZIP CODE<br><b>APT. 203<br/>6711 PARK HTS. AVE. 21215</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAX KANNER</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PAULINE ROSEN</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-48-3566</b>  |  | 17. INFORMANT<br><b>HENRY PUMPIAN APT. 203</b>  |  | 17. ADDRESS<br><b>6711 PARK HTS. AVE. BALT., MD 21215</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>OLD MYOCARDIAL INFARCTION</b>   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><b>Diabetes mellitus</b>   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7-5-84</b> 19 <b>84</b> , to <b>7-5-84</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7-5-84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>7-5-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ORLANDO B. CONNOR MD</b>  |  | 22e. ADDRESS<br><b>3064 RANDALLSTOWN RD 21133</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>7/8/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMUNO</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>               |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br><b>JUL 10 1984 [Signature]</b>  |  |   |  |

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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4 FOR THE MEDICAL EXAMINER. RETAIN PAGE 5 FOR YOUR FILES. RETAIN PAGE 6 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 (AND 2 SHOULD BE FILED) WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | REG. NO.                                     |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CATHERINE QUINN</b>   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>July 29 1984</b>                     |  |   |  | 2b. HOUR <b>2:15 P.M.</b>                    |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>21</b> YEAR <b>1987</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>96</b> YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> |  | 7c. DATE PRONOUNCED DEAD <b>July 29 1984</b> |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore CO. MD</b>   |  |  |  |
| 12. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC</b> |  |   |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>   |  | 15. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |  |  |  |
| 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE <b>Maryland</b> 16b. COUNTY <b>Baltimore</b>  |  | 17. CITY OR TOWN <b>Baltimore</b>  |  | 18. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 19. STREET ADDRESS <b>1223 Camberwell Rd.</b>   |  | 20. <b>21228</b>  |  |  |  |
| 21. FATHER'S NAME<br>FIRST <b>Benjamin</b> MIDDLE <b>Green</b> LAST <b>Green</b>   |  |  |  | 22. MOTHER'S MAIDEN NAME<br>FIRST <b>Jane</b> MIDDLE <b>Weir</b> LAST <b>Weir</b>                         |  |   |  |   |  |  |  |
| 23. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  | 24. SOCIAL SECURITY NO. <b>214-07-0055</b>   |  | 25. ADDRESS OF INFORMANT <b>Albert Custer, Baltimore, Md.</b>   |  |   |  |   |  |  |  |
| 26. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Generalized ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>5+ yrs</b><br>(b) <b>Intestinal Obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>1st Moxs</b><br>(c) <b>Sudden</b>          |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |   |  |  |  |
| 27. DATE OF OPERATION  |  |  |  | 28. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 29. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>   |  |  |  |
| 30. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 31. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |   |  | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 34. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 35. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 36. I certify that I took charge of the remains described above, held on death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> .<br>22a. Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |   |  |   |  |   |  |  |  |
| 37. ACTUAL SIGNATURE <b>Charles O'Donneller</b>  |  |  |  | 38. TITLE (SPECIFY) <b>Deputy</b>   |  |   |  | 39. MEDICAL EXAMINER  |  |  |  |
| 40. EXAMINER'S NAME (TYPE OR PRINT) <b>Charles O'Donneller</b>   |  |  |  | 41. ADDRESS <b>Baltimore, Maryland</b>  |  |   |  | 42. DATE SIGNED <b>7/29/84</b>  |  |  |  |
| 43. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |  |  | 44. DATE <b>Aug. 1, 1984</b>  |  |   |  | 45. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Pk. Frostburg, Md.</b>  |  |  |  |
| 46. FUNERAL DIRECTOR NAME <b>Durst Funeral Home, Frostburg, Md.</b>  |  |  |  | 47. ADDRESS <b>Aug 7</b>  |  |   |  | 48. DATE REC'D. BY REGISTRAR <b>Aug 7</b>   |  |  |  |
| 49. REGISTRAR'S SIGNATURE <b>John J. ...</b>   |  |  |  | 50. REGISTRAR'S SIGNATURE   |  |   |  | 51. REGISTRAR'S SIGNATURE   |  |  |  |

QUINN

CATHERINE

96

FEMALE WHITE 9/21/87

APRIL 1988

GBHC

Baltimore

1323 W. BELMONT ST. BALTIMORE, MD 21201

QUINN

GREEN

GREEN

GREEN

514-77-0053, Robert Quinn, Baltimore, MD.

Baltimore, Maryland

Charles C. Quinn

1001 N. 1st St. Baltimore, MD 21201

1001 N. 1st St. Baltimore, MD 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

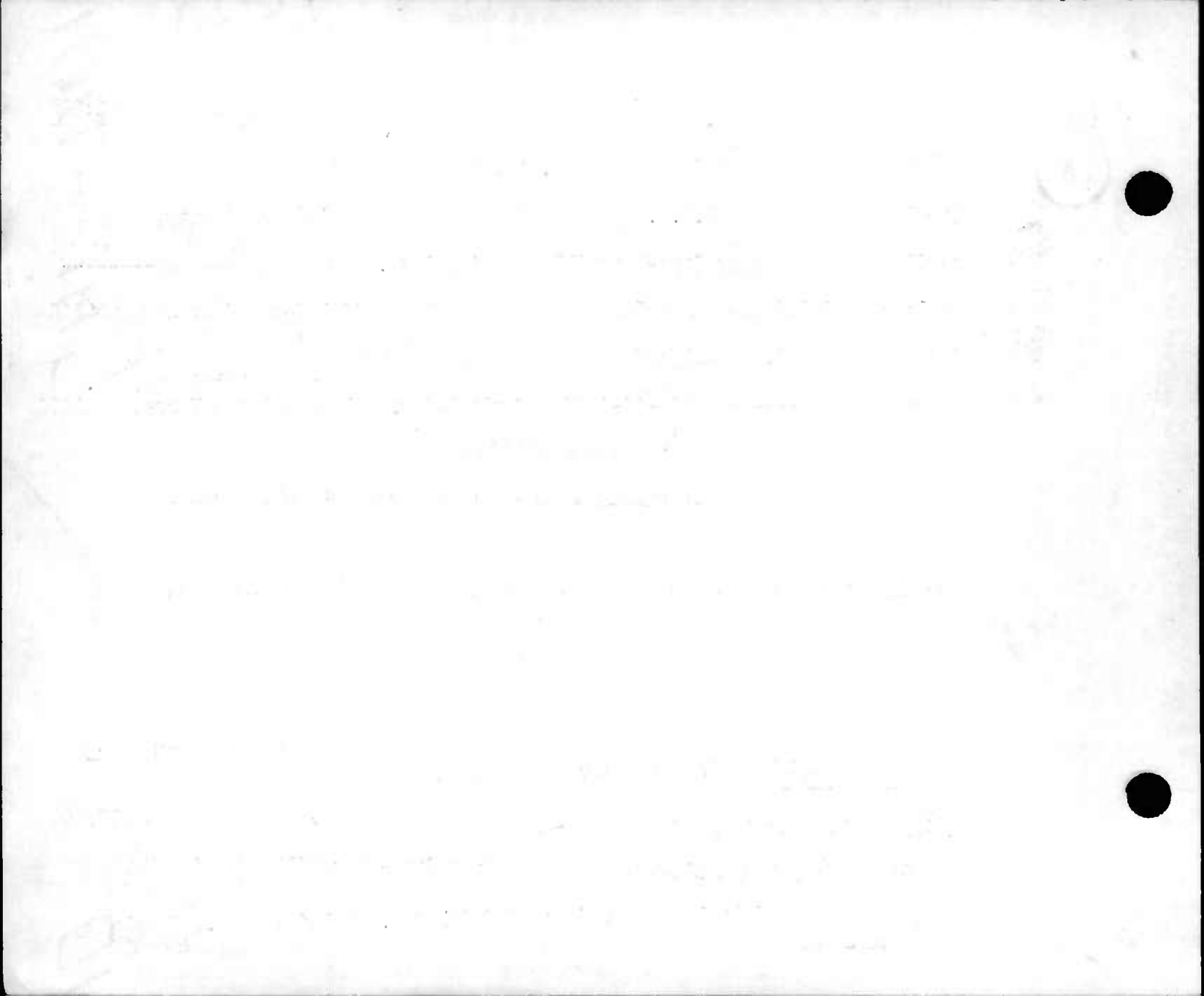
1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Anna M. RASSA   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 11, 1984                           |   | 2b. HOUR<br>2:29P M  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 10, 1891   |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>92 YRS  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Manor Care-Rossville Nursing Cntr |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home maker |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Overlea   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George C. Holdorf  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Lang  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>220-44-2966   |  | 17. INFORMANT<br>Doris Anderson 100 Belhaven Terrace Baltimore, Md.                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>1) Severe Senile Dementia 2) Chronic Hypertension</u>  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| I hereby certify that (I) this hospital attended the deceased from <u>8-30</u> , 19 <u>79</u> , to <u>7-11</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>7-11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.                                     |  |   |  |   |  |
| 22a. SIGNATURE<br>Samuel Westrick  |  | DEGREE  |  | 22c. DATE SIGNED<br>July 12, 84   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL J. WESTRICK  |  | 22e. ADDRESS<br>Manor Care- Rossville Nursing Home  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>July 14, 84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. Maryland                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dupel Funeral Homes, Inc.  |  | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.   |  | 25a. DATE REC'D BY REGISTRAR<br>JUL 13 1984   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |                                   |                  |          |
|--|--|---|--|--|--|--|-----------------------------------|------------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | LAST  |  | 20. DATE OF DEATH  |  | MONTH  | DAY                               | YEAR             | 7b. HOUR |
| HELMUT GEORGE RAU  |  |   |  | July 23, 1984  |  |  |                                   |                  | 6:50 pm  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. UNDER 1 YEAR  |                                   | 7. UNDER 24 HRS. |          |
| Male   | White  | Aug. 15 1925  |  | 58   |  | YES  |                                   |                  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |                                   |                  |          |
| Germany  | USA  |   |  | Baltimore County MD.   |  |  |                                   |                  |          |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |                  |          |
| Towson   | St. Joseph's Hospital  |   |  | Owner  |  |  | Parkville Body & Fender           |                  |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMITTING)   |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS / ZIP CODE                                 |                                   |                  |          |
| 13a. STATE   |  | 13b. COUNTY   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 4819 Carroll Manor Rd. 21013                                   |                                   |                  |          |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |                                   |                  |          |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST   |  |  |  |  |                                   |                  |          |
| Christian Rau  |  | Elise Burhardt  |  |  |  |  |                                   |                  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |  |                                   |                  |          |
| yes  |  | WW2   |  | 220 20 1104 family records   |  |  |                                   |                  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.  |  |   |  |  |  |  |                                   |                  |          |
| IMMEDIATE CAUSE (a) Acute Myocardial Infarction with Arrhythmia  |  |   |  |  |  |  |                                   |                  |          |
| DUE TO, OR AS A CONSEQUENCE OF, (b) Coronary Artery Disease 4+ yrs.  |  |   |  |  |  |  |                                   |                  |          |
| DUE TO, OR AS A CONSEQUENCE OF, (c) Arteriosclerotic Vascular Disease  |  |   |  |  |  |  |                                   |                  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None  |  |   |  |  |  |  |                                   |                  |          |
| MEDICAL CERTIFICATION  |  |   |  |  |  |  |                                   |                  |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |                  |          |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |                  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)   |  |  |                                   |                  |          |
|  |  | P.M. 19   |  |  |  |  |                                   |                  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION (CITY OR TOWN, COUNTY, STATE)  |  |  |                                   |                  |          |
|  |  | Harford   |  | Harford 57 July 34   |  |  |                                   |                  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (II) (this hospital) was not involved in the death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. |  |   |  |  |  |  |                                   |                  |          |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |                                   |                  |          |
| Frank T. Kasik, Jr. M.D.   |  |   |  |  |  | 7/26/84  |                                   |                  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |  |                                   |                  |          |
|  |  | 9005 Harford Road 21234   |  |  |  |  |                                   |                  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE)                    |                                   |                  |          |
| burial   |  | 7/27/84   |  | Dulaney Valley Memorial  |  | Balto. County, MD.   |                                   |                  |          |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |                                   |                  |          |
| Evans Chapel of Memories   |  | 8800 Harford Road   |  | JUL 27 1984  |  | Julia Davidson-Henderson                                       |                                   |                  |          |

